Nursing Homes

OFFICIAL JOURNAL - AMERICAN NURSING HOME ASSOCIATION

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1960

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1961

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Exhibitors at ANHA 1961 Convention

October 2-6, 1961
Cleveland, Ohio
Hotel Pick-Carter

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3	American Laundry Machine — Cincinnati, Ohio
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Message To ANHA Convention Delegates, Guests and Exhibitors

The joining of forces of the American Nursing Home Association and the American Society for the Aging, in a national program for improving the outlook of all America's aging, will be a major topic at the ANHA's 12th annual convention in Cleveland, October 2-6.

The new nationwide plan of action against problems of the aging contains many provisions stemming from recommendations made during the White House Conference on Aging. In addition, the program has a unique "volunteer" aspect to stimulate national interest and participation.

Encouraged by the U. S. Department of Health, Education and welfare, the action-on-aging plan will be represented throughout the United States by the ANHA membership of 5,000 institutions with the aim of having a chapter in every town of size in the nation.

The ANHA-ASA combination will form a network for organizing, recruiting and training volunteers to provide community service for the aging. At the same time, ANHA President Alton E. Barlow has emphasized the following policy concerning the two groups:

"ANHA will in no way merge or appear to merge with ASA. ANHA will in no way affiliate or appear to affiliate with ASA. ANHA will cooperate with ASA to the fullest extent of its physical and human resources."

Leo Glass, general convention chairman, said the detailed ANHA-ASA plan of national cooperation — expected to enhance immeasurably the prestige of nursing homes in America — is one part of the convention program that makes attendance "a must" for everyone remotely concerned with operation or administration of a nursing home.

Miss Mary Pickford, "America's Sweetheart" since the silent movies, and now a co-chairman of the American Society for the Aging, will receive the ANHA "Humanitarian Award", to be presented October 5.

The same day announcement will be made of a "Golden Achievement Award" sponsored by Rainbow Crafts of Cincinnati. Throughout the convention week, Rainbow Crafts will conduct demonstrations to show how its product can be made to serve the purposes of nursing homes.

"Nursing Homes in a Changing America" will be the theme of the week-long ANHA convention at the Pick-Carter Hotel, Prospect and East Ninth Streets, Cleveland, Ohio.

More than 70 exhibits will present the largest display in ANHA convention history. They will represent equipment, merchandise and services important in the modern nursing home industry.

In the "work shop" department, small group discussions called "trading posts" will allow exchange of ideas among all members. A member can simply "table-hop" until he finds a discussion of particular interest to him.

Experts at "trading post" tables will include leaders from the American Institute of Architects, the Mortgage Bankers Association of America, and the General Contractors Association of America.

Mayor A. J. Celebrezze of Cleveland will welcome delegates to the convention. Other speakers whom ANHA members will want to hear include:

Dr. Tennyson Guyer of Findlay, Ohio, industrial public relations director and former Ohio State Senator, who will deliver the convention keynote address Tuesday morning, Oct. 3;

Roger Fleming, secretary-treasurer and director of the American Farm Bureau Federation's Washington office, who will be the speaker Tuesday afternoon;

Dr. Kenneth McFarland of Topeka, Kansas, educational consultant and lecturer for General Motors Corporation, who will be principal speaker at the convention banquet, Thursday evening, October 5; and

Mrs. Helen F. Holt, special assistant to nursing homes, Federal Housing Administration, who will address the Wednesday afternoon session, October 4.

Because of the variety of subjects vital and interesting to ANHA members, which will be covered during this week-long convention, President Alton E. Barlow and General Convention Chairman E. Leo Glass sincerely believe that all delegates, guests and exhibitors will find this 12th Annual Convention of the American Nursing Home Association, being held October 2-6, 1961, at the Hotel Pick-Carter, in Cleveland, Ohio — the most comprehensive, informative, inspiring and productive convention in the history of the ANHA.

Blue Shield in Relation to Basic Issues of Future Medical Care

By NED F. PARISH
Assistant Executive Vice President
National Association of Blue Shield

Where does Blue Shield stand in relation to these and other issues basic to the future of medical care as we know it, and to the principle of employing private initiative in solving the economic problems involved in financing the cost of health services?

I should like to address my remarks to the broad question of government intervention in the practice of medicine and voluntary prepayment. The position of Blue Shield has certainly been well defined in the past and restated on every appropriate occasion. But for the record, let me set forth once more the principles Blue Shield upholds.

A Commitment

First, Blue Shield is fully committed to the preservation of private medical care. This system has produced for our nation the most outstanding and highest order of medical progress ever attained anywhere in the world. Any compromise of this system would inevitably bring deterioration in the quality of our medical care and deprive the medical scientist of the incentives that have proved essential to continuing medical progress for the benefit of the public.

Second, Blue Shield rejects the thesis that adequate health care can only be achieved by governmental means. The institution of federally sponsored programs of health insurance would inevitably involve costs to the taxpayer that would be unjustified and completely excessive when compared to the extent and quality of service that could be expected. Furthermore, government health insurance is urged on the grounds that it will solve for the individual the problem of paying for medical care. In fact, however, a government program simply substitutes a tax obligation for a personal responsibility, since there is no magic in federal legislation that can provide any service or benefit, without cost to the public.

Third, Blue Shield is fully and unequivocally committed to the application of private initiative as offering the most economical means of financing health services. Blue Shield together with insurance organizations, have evolved outstanding programs of health care coverage already providing a substantial measure of security for more than 128 million persons. These programs will continue to be extended to improve their quality in helping people meet more adequately the cost of necessary health care.

Fourth, Blue Shield recognizes that specific segments of the population such as elder citizens, among others, have special needs which must be met by health care coverage. Blue Shield has, from its beginning, demonstrated its awareness of this problem by adopting enrollment and conversion regulations which permit Blue Shield subscribers to continue coverage regardless of age, employment status, or health condition. Moreover, Blue Shield Plans, together with their sponsoring medical societies, are determinedly seeking to develop new forms of coverage suitable to the needs of special groups within the population. This objective has been assigned a high priority in Blue Shield, and a considerable measure of attainment is already reflected in the development by most Plans of "senior citizen" coverage especially equated to meet both the general financial status and special health needs of those persons over age 65 not already covered by Blue Shield.

Here's Progress Report

Let me give you a quick progress report on this important area of coverage. At the time of the AMA House of Delegates Resolution (December, 1958), only six Blue Shield Plans were offering non-group enrollment to persons over 65. Within one month—by January 1959—18 additional Plans were providing this coverage. By June 1960, this number had grown to 34, and today, 47 of the 69 U.S. Blue Shield Plans, representing 71% of the total U.S. Blue Shield membership of 45 million, have non-group programs available to the over 65 person. There are 15 Plans whose membership represents 27% of the Blue Shield total, with programs already developed or in various stages of development, but being held up for one reason or another. If just two of these Plans—New York City and Pennsylvania—were permitted to offer their over 65 coverage, it would mean that Plans with 91% of total Blue Shield enrollment would be providing programs for the aged. Only seven Plans with less than 2% of all Blue Shield membership have no indicated plans for instituting this coverage.

Incidentally, we estimate that approximately 6½ per cent of our total enrollment, or roughly three million persons , are over 65 years of age. I would also point out that today most negotiated health and welfare contracts with large national and local employers, take into consideration continuation of coverage for their retiring employees. Thus, coverage of the elderly citizen will become less and less a concern of government.

Fifth, Blue Shield believes that private interests in competition to produce better forms of health coverage will produce programs that cannot be equalled dollar for dollar by any form of government program.

These are Basic Principles

These are principles basic to Blue Shield. They represent fundamental

considerations on which Blue Shield stands with reference to any proposal that would place the responsibility for providing or financing the cost of health services in the hands of government.

Against the background, it must be emphasized again and again that Blue Shield was not organized solely to serve the needs of the indigent. Nor was it organized to forestall "socialized medicine." These were simply conditions that coincided with the development of the Blue Shield program. Actually, Blue Shield was organized by physicians to meet a fundamental economic problem in which the personal security and health of the nation were both at stake. Wisely, physicians foresaw the need to provide people with a means to budget the cost of their accomplished care and developed a practical program by which this could be accomplished. Thus, the Blue Shield idea was created to assist the public generally in paying for its medical care.

Serves Public and Medical Profession

Today, the Blue Shield program seeks to serve both the public and the medical profession by providing the best possible means of paying for medical care. Blue Shield has demonstrated that this can be done without imposing limitations on either the interests of the public or the medical profession. And if physicians will provide the necessary leadership and guidance, both nationally and locally, Blue Shield can accomplish the purpose for which it was intended without any need for government excursions into the field of health insurance.

The blueprint for this leadership has already been spelled out by the AMA House of Delegates through the adoption of the Council on Medical Services' report in June, 1960, and by the adoption of the resolution on prepayment plans development in November, 1960. The Council's report said that Blue Shield, as a proper economic arm of the medical profession, deserves the support of physicians in medical societies and made five recommendations in reference to AMA-Blue Shield relationships:

1. The American Medical Association urges physician participation in Blue Shield Plans.
2. Liaison between the American Medical Association and Blue Shield Plans should be strengthened:
   a. By the Board of Directors of the National Association of Blue Shield Plans accepting two members from the Council on Medical Service in an ex officio capacity. This would be in addition to the three already appointed by the American Medical Association Board of Trustees. This recommendation has already been approved by our Board and will be submitted to the Conference of Plans Committee for their action.
   b. Through at least one formal conference annually between the Council on Medical Service and the Board of the National Association of Blue Shield Plans; and
   c. Through close inter-association staff work, with interchange of information and data for publication by each association. Both of these have been done and have been effected before this recommendation.
3. The American Medical Association encourages direct liaison between medical societies and the Blue Shield Plans serving their areas to maintain the best possible physician-Plan relationship.
4. The American Medical Association encourages such Blue Shield Plans in experimentation directed toward continued improvement in our voluntary prepayment and health insurance system.
5. Each Plan should cooperate in providing such data to the American Medical Association as might be deemed necessary. This has been a standing offer for some time.

Then, translating these recommendations into action, the House as you know, adopted the resolution on prepayment plan development directing the Board of Trustees and the Council to assume immediate leadership in consolidating the efforts of the AMA, Blue Shield, AHA, Blue Cross, toward maximum development of the voluntary nonprofit prepayment concept.

The Joint Commission representing these four national organizations is already at work on these problems. Their responsibility, and the responsibility of each of us, is to provide continuing proof that the voluntary system is the best system. If we are to be medicine's answer to the preservation of this system—the answer to such things as care of the aged, closed panel plans, and the consistent attempts by government to intervene in the practice of medicine, then ways must be found to improve our programs. Benefits must be made more comprehensive, more flexible, and must offer subscribers a reasonable assurance of security against their health care costs.

Suited to Local Areas

There are a great many Blue Shield Plans that already fit those conditions and are providing realistic and comprehensive benefits in their local areas. But there are some Plans that are not doing so and, unfortunately, Blue Shield is judged collectively, particularly by national accounts. These large employers are not too impressed with the fact that x per cent of their employees are covered comprehensively under a high income level Plan when this fact is offset by failure to provide adequate coverage for the balance of their group. Proponents of compulsory health insurance are quick to point out our deficiencies. They stress these inadequacies as if they represent the norm, ignoring the tremendous progress made by the majority.

Perhaps a simplified way of saying all of this, and certainly a shorter way, would be—make your Blue Shield Plans so attractive, so workable, both for the public and the profession, that government programs will lose their appeal and consequently their support.

This can be done if the will to do it is strong enough. It must be done if the free practice of medicine and voluntary prepayment is to survive.

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We are most grateful to all our ANHA presidents for their assistance and guidance.

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Eight Steps To Better Adult Training

You can benefit from new findings on the ways in which adults learn

By LOUIS CASSELS

An insight into the way adults learn can help you do a better job.

Managers today are deeply involved in adult education in three ways — as learners, as teachers and as school administrators.

They are learners because they want to keep on growing and because they recognize that in this complex and swiftly changing world no one ever knows all that he really needs to know.

They are teachers because they have a personal responsibility for training younger managers who will some day succeed them.

They are school administrators because American business is now spending more than $2 billion a year to provide formal educational courses for 3.5 million employees — a student body equal to the total undergraduate enrollment of all U.S. colleges and universities.

Modern research has exploded the notion that learning capacity dwindles rapidly as a person ages. It shows that adults can learn effectively at all ages. But it also shows that adults learn in their own way — and this way differs significantly from the way in which children learn.

Not Yet Applied

This discovery has not yet been generally applied to the vast adult educational effort in which business is engaged. Much of the formal and informal training that goes on in the business world is based on the assumption that adults can be taught by the same methods that have proved successful with youngsters.

Extensive studies of adult learning have been carried out at Columbia and Stanford universities; at the Center for the Study of Liberal Education of Adults in Chicago; by the Adult Education Association of the United States; and by the Ford Foundation's Fund for Adult Education. A great deal of work has also been done in Great Britain and Canada.

Here are some of the important facts that educational research has brought to light about the way in which adults learn:

1. Adults must want to learn.

Children will do a certain amount of learning in response to external compulsion. They will, for example, take a course simply because it is required. The desire to make good grades or the dread of flunking will induce them to work hard to master subjects which have no inherent appeal to their interests.

But adults strongly resist learning anything merely because someone says they should. They learn effectively only when they have a strong inner motivation to develop a new skill or to acquire a particular type of knowledge. Their desire to learn may be awakened or stimulated by outside influences, but it can never be forced upon them.

This means that it is a waste of time and money to push employees into required training courses. You can make all your foremen sit through a series of classes on human relations, but only the ones who will benefit will be those who want such instruction enough to take the course voluntarily.

2. Adults will learn only what they feel a need to learn.

Children can be induced to learn many things for which they can see no immediate use. Long-range goals, such as preparing for life or getting into a good college, are often a sufficient motivation to keep them plugging away for years at Latin and algebra.

Adults are much more practical in their approach to learning. They want to know, "How is this going

Methods designed for teaching youngsters may fail

to help me right now?" Sometimes they can be persuaded, through wise counseling, to learn things that will help them in the clearly foreseeable future — as for example, when a promotion is imminent. But they learn best when they expect to get immediate benefits — when the knowledge or skill they are trying to acquire will be directly useful in meeting a present responsibility.

Furthermore, an adult isn't satisfied with assurance that he will eventually learn something useful from a course of study. He expects results from the first class or lecture or home assignment, and from each succeeding installment of the course. He has no patience with teachers (either in a formal course setting or an informal coaching relationship) who insist on giving him a lot of preliminary background, theory and historical review.

Teach Simply

If you want an adult to learn, you must teach him simply and directly what he wants to know: "This is what you do, this is how you do it, this is why it works." If you once let him decide that the training has no relevance to his personal needs, he will become a drop-out — physically, if the training is voluntary; mentally, if his attendance is compelled.

Here's a Clue

Here lies a clue to bettering your investment in management courses. If you send a promising young man through such a course before he has enough managerial experience to discover how much he needs it, he isn't likely to learn a great deal.

There is another implication for executives: Before you start teaching a subordinate all the things that you think he should know, find out what he feels a need to learn. Begin with his agenda, and work up to yours.

3. Adults learn by doing.

So do children, but the importance or active participation in the learning process is greater among adults.

Studies have shown that adults will forget within a year at least 50 per cent of what they learn in a passive way (as, for example, by reading a book or listening to a series of lectures). Within two years, they will forget 80 per cent.

But retention of new knowledge or skills is much higher if the adult has immediate and repeated opportunities to practice or use what he has learned.

This finding explains why on-the-job training is often the most effective type. It also underscores the importance of timing in all types of industrial training, and particularly manager development. If you can schedule a man's learning experiences so they dovetail with his actual operation responsibilities at each stage of his career, he will have a chance to use what he has learned before he forgets it — or dismisses it from memory as irrelevant.

4. Adult learning centers on problems, and the problems must be realistic.

You can teach adults a general rule or principle, and then show them, by a series of hypothetical illustrations, how it applies to specific situations. But studies show that they will learn much faster if you reverse the process.

Applied to Manager Training

This technique has been effectively applied to formal manager training in the case study method developed at Harvard Business School. It can be used equally well in informal coaching relationships.

The importance of realism in

fail

with adults who learn easily but in their own way

adult education cannot be overstressed. Adults simply will not put their minds to work on a problem which is clearly contrived for school purposes. Their common sense keeps telling them, "Yes, but it wouldn't happen that way in real life."

How adult interest soars when training is built around real rather than hypothetical problems was clearly demonstrated recently in an experiment conducted by the New York State Department of Education. Students in adult education classes had displayed a marked apathy toward a citizenship course in which they studied the operations of the state legislature.

Obtains Copies of Bills

Someone had the idea of obtaining from the legislature copies of bills which were under current consideration in committees or on the floor. These pending bills were then used as a basis for discussions in the adult citizenship classes. Debating merits of legislation which might actually be passed in their own state, the students got so wrought up that some classes formed lobbying committees to go to Albany.

5. Experience affects adult learning.

The most conspicuous difference between adults and children as learners is that adults have had a lot more experience with life. This can be an asset; but it can also be a liability.

While the analogy must not be pushed too far, a child's mind may be compared to a slate on which some space is still left for new things to be written. Thus a child can learn by simply adding new knowledge to what he has learned before.

But an adult's mental slate is already pretty crowded. His learning must therefore be relational. The new knowledge must be related to, and integrated with, the accumulated results of a lifetime of learning experiences.

If the new knowledge doesn't fit in with what he already knows or thinks he knows, he is powerfully disposed to reject it. In fact, his past experience may actually prevent him from perceiving accurately, let alone absorbing the meaning, of newly presented data.

In his book "How Adults Learn" (Association Press), Dr. J. R. Kidd tells of an ingenious experiment which demonstrated the effect of experience upon adult perception. The experimenter put a blob of red on a card and flashed it before the adult students for a fraction of a second and asked them what they saw. All of them said they saw red.

Next he took an identical card on which the red spot of similar size was in the shape of the ace of spades. This time, not a single student reported that he saw red when the card was flashed. Some saw gray, some brown, some purple. Past experience in seeing a spade as black rendered them unable to see a red spade when it was held before their eyes.

The moral is this: "When trying to reach adults, you must give them every opportunity to interrupt, to ask questions or to argue. Through a free give-and-take you can find out what their experience has been, and what set views they have acquired from it. Then, if you are skillful, you can present the new idea in such a way that their experience will tend to reinforce, rather than contradict, it.

6. Adults learn best in an informal environment.

"Let them smoke," says Tom McLernon, former director of adult education of New York state, and now an adult education consultant to the National Education Association.

Adults have Unpleasant Memories

It may sound like trivial advice, but it symbolizes a most important consideration in adult learning. Many adults have unpleasant memories of their school days. They will respond to adult educational programs in inverse relationship to the degree they are reminded of their childhood experiences. Smoking in class, which is the last thing they would have been allowed to do in the seventh grade, gives them needed reassurance that there is nothing childish about their present engagement with the learning process.

7. A variety of methods should be used in teaching adults.

This is one instance in which adult educators should borrow the techniques that have proved effective with children.

Educational research demonstrates that learning proceeds most quickly, among adults or children, when information reaches the learner through more than one sensory channel.

Visual Aids do the Trick

That's why a movie, a film-strip, a flip-chart or other visual aids can do so much to heighten the net impact of a lecture or other verbal exposition. The executive who reaches for a scratch pad and begins drawing a diagram when he tries to explain a complicated matter to a subordinate is displaying an intuitive grasp of this point.

There is another, more basic reason for using a variety of methods in teaching adults. The method should be adapted to what you are trying to accomplish. If your main purpose is simply to impart information, the most efficient method is some version of the lecture. (A movie is, in the eyes of the educational psychologist, simply a lecture with pictures; a symposium or panel presentation is a lecture broken up into several parts; a demonstration is an acted-out lecture.)

But if the purpose is to bring about a change in the conduct, attitudes or ideas of the learner — which is frequently the case in adult education — you must involve the learner activity in the process. That is, you must use a discussion method.

This applies to the informal teaching which you do as an executive every day, as well as to any formal courses of training that may be under your supervision. If you want to transmit a fact to a subordinate, you simply tell him. If you want to induce a change in him (such as growth), you'll have to talk with, rather than at, him.

8. Adults want guidance, not grades.

Competition may be a spur to academic achievement among children (many educators question whether it is) but it certainly has a

(con't. on page 10)

New Type Research and Demonstration Project Announced

A new type of research and demonstration project designed to increase, intensify, and improve rehabilitation services for persons with extremely severe disabilities was announced recently by Miss Mary E. Switzer, Director of the Office of Vocational Rehabilitation.

Grants totaling $380,703 have been made in support of five projects in Massachusetts, Pennsylvania, West Virginia, Michigan, and Texas. In the 1962 budget, $750,000 has been requested for similar projects.

Award Made

Of the $380,703 grant total, $78,168 was awarded to the Massachusetts Rehabilitation Commission working in close conjunction with the Boston Dispensary Rehabilitation Institute; $70,000 to the Pennsylvania Bureau of Vocational Rehabilitation for work at its new rehabilitation center at Johnstown; $83,044 to the West Virginia Division of Vocational Rehabilitation; $69,999 to the Rehabilitation Institute, Detroit, Michigan.; and $79,492 to the Texas Institute for Rehabilitation and Research, Houston, Texas.

The new projects are directed toward service for those people who currently are receiving monthly disability cash payments under the disability provisions of the Old-Age, Survivors and Disability Insurance program.

The disabilities in such cases are of such severity as to require intensive and long-term services, generally at high cost and in areas away from the disabled person's home. In such cases the experience developed is expected to demonstrate the effect of comprehensive and intensified services on readily identifiable groups of the severely disabled.

Sufferers from such disabilities as cardiovascular, neuromuscular or respiratory conditions are expected to be the chief beneficiaries of the work.

New Techniques and Methods

Among the project objectives will be an exploration of new techniques and methods leading to advanced knowledge concerning: (1) the rehabilitation potential of the severely handicapped; (2) the nature of services, facility programs, and patterns of organization needed for serving this group effectively; (3) data on the cost of rehabilitating them; (4) methods for improving inter-agency effectiveness; and (5) an evaluation of feasibility and current eligibility standards.

These objectives will be sought by providing a complete range of services for the severely disabled through the State rehabilitation agencies and established voluntary facilities, from initial evaluation to job placement and follow-up. Special surgical treatment and other rehabilitative measures, not now ordinarily available to this type of person under the service programs of the State agencies, also will be provided.

Role of Medicine in Malpractice Litigation Outlined

Reprinted with permission from AMA News, May 29, 1961.

"Twenty years ago, the patient hoped to be cured; now he expects to be cured," said Joseph F. Sadusk, Jr., MD, Oakland, Calif., at a recent American Medical Association medicolegal conference in Louisville.

Dr. Sadusk, chairman of the AMA Subcommittee on Medical Liability, said that if the patient isn't cured he may believe that his physician was negligent.

Physicians are "courageously accepting" their responsibilties in seeing that justice is served in malpractice litigations, said Dr. Sadusk.

Three Phases: He reviewed three phases of medicine's role in professional liability litigation; first, the review of malpractice charges against the physician; second, the institution of malpractice claims and prevention programs; and third, the furnishing of expert medical advice to the plaintiff-patient.

More than 31 states have committees of physicians to review malpractice charges against a physician. Dr. Sadusk told of his 10 years experience with his local review committee which includes a lay person, usually a prominent clergyman, as a voting member.

"It is interesting," he said, "that these lay members invariably believe that the physician committee members are overly critical of the defendant physician."

He said there are a number of attorney-physician panels which act in joint session to screen malpractice claims against doctors. It is too soon to say whether such plans will be successful, said Dr. Sadusk, but he mentioned that one in Pima County (Tucson), Ariz., is still operating four years after it was formed (*The AMA News,* Aug. 8, 1960).

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EIGHT STEPS

(con't. from page 8)

negative effect on adult learning. Most adults are apprehensive about their learning capacity because they have been a long time out of school, and they have been assured repeatedly (if falsely) that you can't teach an old dog new tricks. If they are confronted with tests, grades and other devices for comparative evaluation of their progress, they will draw back from the whole experience for fear of being publicly humiliated.

At the same time, the adult learner wants desperately to know how he's doing. He needs to know whether he is learning correctly, whether he's doing it right, whether he has got the basic idea straight in his head, before he can continue learning.

Robert Luke, executive secretary of the National Association of Public School Adult Educators, recommends "guided self-evaluation" for adult learners.

"The adult should be encouraged to measure his own progress," says Mr. Luke. "He knows better than anyone else what he set out to learn, and whether his performance has measured up to his goals."

Actually, it rarely does. Adults tend to set exacting goals for themselves; often, they bite off more than they can chew. They are impatient with their own errors, and easily become discouraged about their ability to learn. This means that they need as much praise as the teacher (or their superior) can honestly give them. If it is absolutely necessary to criticize an adult student, do it in strict man-to-man privacy — and always with a smile. *Reprints of "Eight Steps to Better Training" may be obtained for* 10 *cents a copy or* $7.00 *per* 100 *postpaid, from Nation's Business,* 1615 *H Street, N. W., Washington* 6, *D. C. Please enclose remittance.*

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A Three Point Program

For the Dental Health Care of the Chronically Ill and Aging
Developed by the Connecticut State Dental Association

GERALD L. ST. MARIE, D.D.S.

The first step was the action taken, when the representatives of the Connecticut State Dental Association at the meeting of the Joint Council to Improve the Health Care of the Aged, which was held in Washington, D.C., on June 12-14, 1959, brought back recommendations to the Board of Governors of the Connecticut State Dental Association on June 18th, 1959.

At a subsequent meeting of the Board of Governors, a Committee on Gerontology was appointed and began to function on July 15th, 1959. A three-point program was adopted:

POINT 1.

Professional information.

a) Post-graduate training for dentists who are interested in doing a better job for aging patients by presenting a two-day post-graduate course stressing new techniques. Course was held September 14-15th at the Yale-New Haven Medical Center.

b) Dissemination of dental information to members of the medical profession through a joint medical-dental conference committee.

c) An article on dental health of the aging, to appear in each issue of the Connecticut State Dental Journal.

POINT 2.

An educational program for the aged.

Short talks by a dentist, with visual aids, are being given in senior centers and Golden Age Clubs throughout the State.

POINT 3.

To bring together the various organizations, public and private, from the areas of health, education, welfare and rehabilitation in order to provide the basis for a coordinated regional, state, and local program for the rehabilitation of the aging, with particular emphasis upon adequate and comprehensive dental services to aging homebound and institutionalized bedfast patients.

In keeping with the above stated needs and plans, for providing for their solution, a two day post-graduate course on Dental Care for the Rehabilitation of the Chronically Ill and Aging was held at the Yale-New Haven Medical Center September 14-15, 1960, for members of the Connecticut State Dental Association and representatives of the remaining New England State Dental Societies and Dental Chiefs of the New England Public Health Services.

As a follow up to this seminar, the Committee on Gerontology planned a workshop for some forty-five members of the Connecticut State Dental Association who had previously attended the post-graduate seminar on Dental Care for the Chronically Ill and Aging, which workshop was held at the Hunt Memorial Building in Hartford on November 30, 1960.

The purpose of this workshop was to find out what they, as participants of the Seminar, derived from it, their reactions and thinking; to determine whether their enthusiasm warranted a continuation of this program.

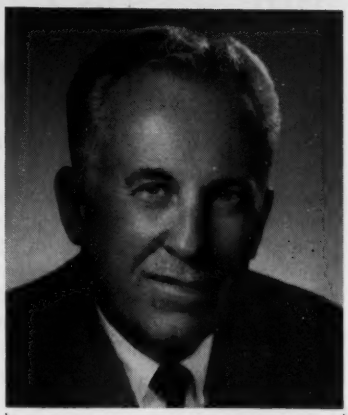
The participants were evenly devided into three groups and discussions of the previously mentioned topics took place from 1:30 P.M. until 3:15 P.M. The topics were:

Group A: The Connecticut State Dental Association organization for post-graduate medical-dental training in the rehabilitation of the chronically ill and the aging.

Group B: Official agencies in Connecticut concerned with the care of the chronically ill and aging.

Group C: Institutional and dental care programs required to meet the needs of the patients and residents. Each workshop then returned with recommendations to be considered by the Committee on Gerontology. The Committee selected those which could be implemented with the greatest immediate value. These were:

1. That a need exists for a joint Dental-Medical program for the chronically ill and aging;



Dr. Gerald L. St. Marie (D.D.S.) graduated from Emory University School of Dentistry in 1928. He is a Fellow of the International College of Dentists; chairman of the Committee on Gerontology, Connecticut State Dental Association; and director of the Medical-Dental Orientation Course for the Chronically Ill and Aging, sponsored by the Connecticut State Dental Association and the Connecticut State Medical Society.

2. The orientation course should cover hospital, chronic and convalescent hospitals, homes for the aged, and boarding homes medical-dental care;
3. The Directors of the four areas to be covered (point 2) should cooperate. (They had already expressed their desire and willingness to do so.)
4. Physicians, dentists, dental hygienists and nurses should participate with other disciplines possibly added later.

Justification for a joint medical-dental program was as follows: That it should be most desirable to initiate a program for orientation of both dentists and physicians directed toward the medical-dental care of the chronically ill and aging population of Connecticut. We hope to demonstrate the benefits which can be achieved by the establishment of such a program.

There are many common problems in this group of patients which can be improved by a relatively simple treatment program. However, physicians and dentists must be made aware of the prevalence of these problems and must be stimulated to attack them vigorously.

Regarding the institutionalized patient, it will not be sufficient to train dentists alone; in most cases

physicians will have to make referrals before the dental treatment can be initiated. We must attempt to overcome the pessimism regarding treatment of this group which is present in a significant segment of our professions. We would hope to demonstrate that often a seemingly small improvement in a patient's condition by our own standards, is a tremendous stimulus to the patient's morale. We must convince both physicians and dentists that they often underestimate the value of treatments which they give this patient group.

Physicians should be included in this program because of the complex medical problems found in this patient group. Often procedures which are insignificant in younger patients are poorly tolerated in the aging chronically ill. The physicians must be able to inform the dentist when such a problem is present. On the other hand, the dentist must be given the opportunity to acquaint the physician with dental treatments which can often contribute to marked improvement in problems of nutrition, speech and tempero-mandibular joint dysfunctions.

In summary the problem would be directed toward increasing the awareness of the problems found in the chronically ill and aging population. It would emphasize the importance of a combined medical-dental team approach in correcting or at least, minimizing these problems. Finally, we would hope to create an air of optimism that should exist in regard to treatment of these people.

Beginning May 3, 1961, the Connecticut State Dental Association, Connecticut State Medical Society, Connecticut Hospital Association, Connecticut Chronic and Convalescent Hospital Association, Chronic Disease Program, U. S. Public Health Service, Department of Health, Education and Welfare; and the Connecticut State Department of Health acted as co-sponsors in the projection of a clinical teaching Institute for the Medical-Dental Rehabilitation of the Chronically Ill and the Aging.

The orientation course was planned primarily to include participation by member physicians and dentists, with other disciplines being added later. The cooperation of "chronic and convalescent" hospitals and various other groups interested in the care of the aged has been encouraged and is being received.

Upon completion of this course, and as soon as portable equipment is available, members of the Connecticut State Dental Association will cooperate very closely with those *chronic* and *convalescent* hospitals that ask for professional consultations and services for their patients. The member hospitals of the Connecticut Chronic and Convalescent Hospital Association of the greater New Haven Area have volunteered to donate to the New Haven Chapter of the Connecticut State Dental Society portable equipment necessary to carry out these services.

The medical-dental institute has already given impetus to providing high quality dental care for our chronically ill and aging, and will help achieve objectives more quickly, and effectively, through post-graduate training sponsored by our state dental and medical societies with the cooperation of all professional disciplines interested in the problems of the chronically ill and aging.

Information from Georgia State Fire Marshal

Recently, a memorandum was directed to the State Fire Marshal, Mr. F. E. Robinson, relative to the necessity of at least one nurse or attendant, being dressed, on duty and awake, throughout the night in any nursing home or home for the aged.

A reply from the State Fire Marshal stated that "The requirement in Section 2365a, Georgia Safety Fire Regulations for Nursing, Convalescent and Old-Age Homes, that an attendant be on duty at all times is a nationally recognized standard for nursing homes. Due to the fact that evacuation is a problem which is considerably more difficult in nursing homes than in most any other type of occupancy, we feel we must hold strictly to this requirement. The 1960 Edition of the National Fire Protection Association Building Exits Code goes on to provide that not less than one (1) person and one (1) attendant be provided for every twenty-five (25) persons or fraction thereof in one-story buildings; and for every twenty (20) persons in two-story buildings; and for every fifteen (15) persons in three stories or more in height; and that not less than one (1) attendant shall be on each floor provided that the standby attendant requirement may be waived where a building is completely automatically sprinklered."

An eight page, yellow covered brochure, containing Section 2350A-2396 of the 1957 Edition of the Building Exits Code as referred to in Regulation 35 of the Georgia Safety Fire Regulations for Nursing, Convalescent and Old Age Homes, has recently been published by the office of the Georgia Safety Fire Commissioner, State Capitol, Atlanta 3, Georgia. It has already been pointed out to Hospital Service in a letter from Mr. Ben Kirby, State Fire Inspector, that under the provisions of the Georgia Safety Fire Law and Regulations, "a frame building cannot be opened as a nursing home." This last quoted statement does not apply to facilities already in operation prior to February 1, 1961, but does apply to any new facilities established after that date.

Legislation Affecting the Health Care of the Patient in Relation to Social Security Mechanism

By FRANK S. GRONER

By FRANK S. GRONER, President, American Hospital Association; and Administrator, Baptist Memorial Hospital, Memphis, Tennessee

I think it is a characteristic of a dynamic society that the solution of one problem often creates others and the very things that have made this nation great from the standpoint of care of the patients, have created the problems which we have today.

The American Hospital Association has listed nine problems which we consider the most important facing the voluntary hospital system of America today. It is significant that the two which are most pressing are in the tenor of the socio-political climate in which we find ourselves. Each is directed to the same goal and is an effort to avoid danger.

The purpose of each is to assure the people of our nation the finest hospital care possible at the lowest cost to the public. I refer to the reorganization of Blue Cross and financing the health care of the aged.

Opportunity to Pre-Pay

In my opinion the development of Blue Cross—the voluntary non-profit prepayment program of hospitals—should afford everyone in this country the opportunity to prepay the cost of quality care at the lowest possible cost.

In considering the use of Social Security or any other mechanism for financing the health care of any segment of the population, the guiding principle should be that of what program will best serve the people of our country.

Undoubtedly health care for the aged has been uppermost in the minds of many Americans recently. Last September, the Kerr-Mills bill, providing a program for the medically indigent, was passed by the Congress and signed by the President. We think this is a bill with which the voluntary hospital system can live. There is an urgency that all of us in our respective states do everything possible to implement this legislation. This is a voluntary program at the state level that takes care of the people who need the care most, who need the most help. It has a minimum of federal control.

The American Medical Association and the American Hospital Association are in agreement that the government's responsibility should be a limited one but that it should extend to the health care of the indigent and the medically indigent of all ages.

The American Hospital Association has opposed the use of the Social Security mechanism for financing the health care of the aged. Our basic opposition is one of principle. No matter what we call a health program using the Social Security taxing system, it is compulsory health insurance. Any such program has certain inherent dangers and it is doubtful that a law can be written which avoids these objections. We think the dangers are real. Let me just list a few of them.

Detrimental to Patient

First, the government as a purchaser of so much hospital care, will use the power of the purse in ways which could be detrimental to the interests of a hospital patient. The government would, as it should, be interested in economics and, as we have seen in other programs, the cost would become primary. Quality of care would be relegated to a secondary position.

We also think that this matter of cost will cause concern on the part of the government to the point that it would interfere in the administration and operation of hospitals and because of the intimate relationship of hospital cost to the quality of service, it would lead to interference in the care of patients.

Secondly, any under-estimation on the part of the government as to the cost of the program could be reflected in pressures to reduce the cost of care which would result in a reduction of the quality of care. Here are a few figures. The first "guesstimate" was that the Forand bill would cost about 650 million dollars a year. In a testimony before the House Ways and Means Committee in 1959 on the Forand bill, the Secretary of HEW estimated the cost to be 1.2 billion dollars, almost double the first amount.

Doubles Figure

Subsequently, at the request of Wilbur Mills, Chairman of the Committee, the insurance industry made an estimate and again approximately doubled this figure to about 2.25 billion dollars.

Now, let's look for one moment at the estimate of the cost of HR 4222 which is the companion bill to S 909, the Anderson-King bill sponsored by the present administration, and its estimate is 1.1 billion dollars. When one compares this with the Forand bill, he is impressed with the fact that the estimates are very similar. However, we must not forget two things. A little closer scrutiny reveals that a savings to the government will accrue by cost now passed on to patients — over one-fourth billion dollars in institutional cost—through a deductible. In addition, the fees of doctors have been excluded. The point I am making is that even the government has reduced by 40 to 45 per cent the total benefits and retained about the same cost estimate. I will talk a little more on cost in a moment.

Third, the use of the Social Security mechanism implies a commitment of such magnitude by the federal government that there is little possibility of later retraction. In other words, it is virtually an irrevocable step. I heard an insurance official make this statement, if this bill were enacted and in six months the government saw it had made a mistake and attempts to withdraw, that on an "insurance basis" the government will still have obligations beyond the year 2050.

To give some idea of the cost of the program, by the time it goes into effect, there will be approximately 15 million people over 65 covered. In an insurance program, the rate

of admission to hospitals for those over 65 years of age is about 25 per cent per year and they remain an average of 16 days. Even with the $90.00 deductible, this means the government's obligation would amount to equivalent of over 48 million days of hospital care at an average of approximately $31.00 per day, or 1.5 billion dollars.

A Reminder

Now I would remind you this is for hospital care. This does take into consideration care in nursing homes which in all probability would be as costly as that of hospitals. In other words, an estimate of 2.5 billion dollars for the program based on present hospital utilization cost and the nursing home, seems more accurate. I would caution, however, this does not provide for the cost of out-patient services, home care programs, nor any increase in utilization. If the experience of other compulsory health programs are any criteria, this will increase greatly.

Fourth, there is a real danger that provision by government of prepaid hospital benefits would lead to over-utilization that could not be controlled, and thus to run away costs. We think this could bring consequences that could be disastrous to the hospital and to the public, as well as the government.

Fifth, another danger, as we see it, is that the greater use of general hospitals by this group would be difficult to control. The individuals would feel that they are entitled to care. This could bring over-crowding of hospital facilities with the result that hospitals would have difficulty in serving the needs of the acute curable patients.

Sixth, acceptance of compulsory health insurance by one group of the population would foster its extension to other groups and perhaps ultimately to the whole population. To illustrate, just yesterday, I heard that there is now a proposal being seriously considered to extend it to the unemployed. Undoubtedly it will be extended to the permanently disabled. I think therefore this can be visualized as just one step toward total compulsory health insurance.

These are real dangers. I express them as an earnest belief and not

(con't. on page 20)

Food specialists who have volunteered their services to A.N.H.A. Left to right: Mrs. Mayme G. Kirkland, BS, MS, Chief Dietitian, Arkansas State Hospital; Mrs. Mescal Johnston, BS, MS, Food Marketing Specialist, University of Arkansas Agricultural Extension Service; and Mrs. Katherine Wilson, Nutrition Consultant, Nursing Home Division, Arkansas Department of Public Welfare.

Turkey Is A Bargain

You'll see terrific turkey values this week on high quality turkeys from the biggest turkey crop in our nation's history. With 10 to 14 pound turkeys selling at lower prices than we usually see for larger toms, any day can turn into a feast day on the most modest budget.

It's expected that we'll eat nearly eight pounds of turkey per person in 1961 — about five times the average yearly consumption of the 1920's. Modern turkey meat is much more flavorful, juicy and tender than turkey used to be; there's a higher percentage of meat to bone on the modern bird; and homemakers are using turkey in a greater variety of ways than ever before.

Roasted turkey can be a glamour treat as it struts on the platter for special occasions, but it's equally delicious in sandwiches or combination dishes. If you really want to see a turkey keep its strut from barnyard to platter, try a rich colored bird cooked on your own outdoor grill. Whole turkeys roast juicy and tender on a turning spit, but it's possible to get just as good results on an ordinary outdoor grill if the turkey isn't too large. Half the ready-to-cook weight of a 10 to 14 pound turkey reaches your table as cooked boneless meat, so you can plan on 20 to 25 four-ounce servings from a 15 pound turkey. At this week's prices, that's only 15 cents a serving.

Barbecue A Half-Turkey

Here are step by step instructions for roasting half of a 10 to 12 pound turkey: Ask your butcher to saw turkey into halves when you buy it. Store one half in the freezer and thaw the other in the refrigerator. Half an hour before cooking time, remove thawed half from refrigerator to warm up while you prepare the fire. Light only about a dozen charcoal briquets and let them burn 15 to 20 minutes — until they're grey all over. Spread hot briquets 3 inches apart in all directions and set grill 3 inches above source of heat. Place a piece of heavy duty foil a little larger than turkey-half over grill and puncture foil in several places to allow juices to drain.

Rinse and dry half-turkey. Sprinkle thoroughly with salt and coat with melted butter or margarine. Place, skin side up, on punctured foil over coals. Coat with barbecue sauce. Roast on grill with cover closed for about two hours, brushing alternately with barbecue sauce and fat as needed. (If your grill has no cover, make a tent over turkey with double layer of foil, but do not seal turkey in foil. Replenish fire with more burning briquets after about an hour's cooking.)

Sample Menus . . .

(For Those Not Requiring Special Diet)

Ask a person about his nursing home and he will likely tell you about the food. Food that tastes good goes a long way toward keeping nursing home residents happy. Food that meets the daily nutritional needs of the residents goes even further toward keeping them well.

For some, good planning and preparation of the normal diet is enough; others need special diets; those who can take normal diets but have trouble chewing need to have some foods ground or chopped.

A diet that satisfies the wants of the people in your home might not satisfy their needs. Check yourself each day to see that you are providing for each patient, (1) at least a pint of milk as a beverage or in cream soups, custards, or creamed foods; (2) two or more servings (two or three ounce size) of high quality protein; (3) four or more half-cup servings of vegetables or fruits, (include in this group a good source of Vitamin C each day and a green or yellow vegetable every other day); (4) four or more servings of enriched bread or cereal. Other foods should be included as needed to complete meals and provide needed food energy. Except in specific instances, no bread or beverage (other than milk) has been listed in menus below:

*See Recipes For:

Baked Ham
Tomato Squash
Corned Beef and Cabbage Bake
Turkey and Rice Chowder
Creamed Dried Beef
Corn Pudding

	4	5	6
Breakfast	Grapefruit with Cherry Center Wheat Chex with Milk Link Sausages Bran Muffins Apple Jelly	Blended Pineapple and Grapefruit Juice Cream of Rice Cooked in Milk Crisp Bacon — Scrambled Egg Toast	Chilled Orange Cubes Raisin Bran — Milk French Toast Homemade Maple Syrup
Lunch or supper	Braised Beef Short Ribs Franconia Potatoes Buttered Frozen Carrots and Green Peas Coleslaw with Honey Apple Cobbler Ala Mode	Oven Braised Pork Chops Baked Potatoes Tomato — Summer Squash* Whole Wheat Bread Apple Crisp	Creamed Tuna in Toast Cups Buttered Stewed Carrots Purple Hull Peas Whole Wheat Bread Gingerbread with Vanilla Sauce
Dinner	Hot Cereal Cooked in Milk with Crushed Pineapple Hot Buttered Bran Muffins Hot Chocolate with Marshmallows	Corn Chowder Hot Buttered Crackers Assorted Sandwich Meats Special Milk Shake Baked Apples	Baked Beans Oven Browned Potatoes Buttered Brussels Sprouts Plain Cup Cakes with Pink Icing Milk

	11	12	13
Breakfast	Blended Citrus Juice Dry Cereal with Milk Omelet with Jelly Center Bran Muffins — Butter	Chilled Grapefruit Sections Rice Krispies — Milk Creamed Ham on Whole Wheat Toast	Stewed Prunes Hot Oatmeal — Milk Pancakes — Honey Crisp Bacon Slices
Lunch or supper	Broiled Chicken Buttered Green Peas with Mint Flakes Baked Acorn Squash with Honey-Butter Sauce Rice Pudding	Hamburger Steak with Tomato Sauce Buttered Steamed Okra Potato Cubes Baked in Butter Molded Apple and Banana Salad Coconut Cake	Tuna-Noodle Casserole Buttered Brussels Sprouts Seasoned Canned Tomatoes Corn Sticks Vanilla Ice Cream Frozen Strawberries
Dinner	Baked Salmon Loaf with Egg Sauce Spaghetti and Tomatoes Buttered Spinach Brownies — Milk	Eggs Ala King on Whole Wheat Toast Buttered Mixed Vegetables Seasoned Turnip Greens Jelly Layer Cake Milk	Hot Bean Soup Cheese — Crackers Citrus Fruit Salad Jam Cake Milk

	18	19	20
Breakfast	Chilled Half-Grapefruit Ham Omelet Hot Biscuits — Butter Honey — Milk	Blended Orange and Pineapple Juice Cornflakes with Milk Crisp Bacon Poached Eggs Whole Wheat Toast	Blended Fruit Juices Plain Omelet Apricot Jelly Hot Muffins — Butter Milk
Lunch or supper	Pork Loin Roast Sweet Potato Casserole with Marshmallow Topping Frozen Broccoli with Lemon Butter Chilled Canned Peaches	Corned Beef and Cabbage Bake* Buttered Carrots Congealed Waldorf Salad Hot Biscuits Apricot Cobbler	Salmon Loaf with Celery Sauce Escalloped Potatoes Seasoned Mixed Greens Pineapple Upside Down Cake
Dinner	Cream of Tomato Soup — Saltines Ham Ala King on Egg Noodles Stewed Dried Apples (no spice) Ice Cream — Plain Cake	Toasted Deviled Ham Sandwiches Steamed Buttered Okra Cherry Gelatin — Cottage Cheese Salad Canned Peaches with Cream — Milk	Vegetable Soup — Saltines Baked Macaroni and Cheese Molded Fruit Salad Gingerbread with Caramel Sauce Milk

	25	26	27
Breakfast	Stewed Prunes Scrambled Eggs Ham Slice Buttered Hominy Grits Toast — Milk	Chilled Orange Cubes Rice Chex with Frozen Strawberries — Milk Poached Egg Canadian Bacon Dry Toast — Butter	Grapefruit Sections Hot Ralston Cooked in Milk Pancakes — Syrup or Honey Crisp Bacon
Lunch or supper	Sliced Roast Turkey Fruited Harvard Beets Baked Potato Chopped Spinach Cranberry Sauce Custard Pie	Spaghetti with American Meat Sauce Buttered Asparagus Molded Fruit Salad Hot Buttered Crackers Chocolate Cake	Frozen Perch Fillets Lemon Slices Herb Rice Mixed Vegetables Tomato Aspic Salad Raisin Pie
Dinner	Baked Beef Loaf with Vegetable Sauce Oven Baked Potato Cubes Buttered Green Beans Corn Muffins Sponge Cake — Milk	Turkey and Rice Soup — Saltines Baked Acorn Squash with Honey Butter Orange and Peach Fruit Cup Cookies — Chocolate Milk	Cream of Tomato Soup — Saltines Turkey Salad Sandwiches Peach Half with Cranberry Relish Center Ice Cream

. . . for a Month

	1	2	3
Breakfast	Orange Juice Hot Oatmeal with Raisins — Milk Cinnamon Toast Scrambled Eggs	Chilled Grapefruit Sections Special K — Milk Bacon Strips — Poached Egg Buttered Whole Wheat Toast	Blended Fruit Juices Cream of Wheat Topped with Grapenuts — Milk Pancakes — Bacon Strip — Honey
Lunch or supper	Beef Roast — Natural Gravy Fluffy Buttered Rice Mixed Greens Apple Sauce Bran Muffins Cherry Cobbler Ala Mode	Hamburger Deep Dish Pie with Biscuit Topping Carrots and Potatoes (in pie) Mixed Fruit & Marshmallow Salad Applesauce Cake	Fried Chicken — Gravy Mashed Potatoes Baked Acorn Squash with Honey Butter Beet Relish Baked Spiced Peach Halves
Dinner	Potato Chowder Assorted Crackers Beef Salad Sandwiches Cold Canned Tomatoes Canned Peaches with Whipped Topping — Milk	Baked Fish with Lemon Butter Buttered Broccoli Potato Salad — Cornbread Butterscotch Pudding — Milk	Creamed Dried Beef* Fluffy Rice Congealed Citrus Salad Loaf Bread Plain Cake with Caramel Sauce Milk

7	8	9	10
Broiled Half Grapefruit with Honey Soft Scrambled Eggs — Crisp Bacon Buttered Toast Peach Preserves Milk	Chilled Tomato Juice Rice Chex — Milk Apple Waffles — Maple Syrup Crisp Bacon	Mixed Fruit Juices Special K with Milk Poached Eggs Buttered Toast	Broiled Half Grapefruit with Brown Sugar Cornflakes with Milk Crisp Bacon Toast — Apple Jelly
Chicken Pie Boiled Potatoes in Jackets Fresh Finely Chopped Spinach Salad — Vinegar and Oil Dressing Canned or Fresh Fruit	Roasted Leg of Lamb — Mint Jelly Lima Beans with Tomatoes Pear and Cottage Cheese Salad Hot Buttered Rolls Lemon Refrigerator Pie	Broiled Veal Cutlet — Tomato Sauce French Cut Green Beans Baked Cream Style Corn Orange & Grapefruit Salad — French Dressing Tapioca Pudding	Baked Beef Liver—Mushroom Sauce Whipped Potatoes Friuted Harvard Beets Lemon Refrigerator Pie
Cream of Celery Soup Baked Hamburger Au Gratin Shredded Carrot Salad in Lime Gelatin Fruit Cup — Cake Slice Milk	Creamed Egg with Ham on Toast Green Beans Buttered Cabbage Canned Purple Plums Milk	Shepherd's Pie with Vegetables Pear & Cottage Cheese Salad Oatmeal Cookies — Milk	Vegetarian Soup Toasted Croutons Baked Macaroni and Cheese Molded Fruit Salad Peanut Butter Cup Cake Milk

14	15	16	17
Orange Juice Hot Protein Plus Cereal — Milk Scrambled Egg — Toast Strawberry Jelly	Blended Fruit Juices Hot Oatmeal with Raisins — Milk Shirred Eggs in Bacon Rings Whole Wheat Toast	Chilled Orange Sections Cream of Wheat Cooked in Milk Soft Boiled Egg Toasted English Muffins Butter — Blackberry Jelly	Orange Juice Wheat Chex — Milk Soft Scrambled Eggs Buttered Cinnamon Toast
Sliced Baked Ham Orange Glazed Sweet Potatoes Seasoned Green Beans Banana Salad with Honey-Peanut Butter Dressing Butter Dressing Peach Cobbler — Milk	Chicken Baked in Lemon Butter Sauce Baked Potatoes Buttered Asparagus Orange-Honey Ambrosia Pumpkin Custard	Beef Pot Roast with Potatoes, Carrots & Gravy Finely Chopped Coleslaw Whole Wheat Bread Ice Cream with Sugar Cookies	Baked Calf Liver with Mushroom Gravy Buttered Green Peas Steamed Cauliflower with Grated Cheese Beet Relish — Banana Pudding
Cream of Tomato Soup Toasted Croutons Fluffy Cheese Omelet Blueberry Muffins Hot Fruit Punch	Grilled Ham-Cheese Sandwiches Buttered Green Beans Congealed Fruit Salad Banana Nut Cake with Fluffy Frosting	Potato-Fluted Frankfurters Broccoli with Cheese Sauce Buttered Summer Squash Yellow Cake with Chocolate Frosting	Whole Meal Sandwich (Cheese, Sandwich Meat, Lettuce and Relish) Steamed Canned Tomatoes Congealed Carrot and Pineapple Salad — Cherry Dumplings

21	22	23	24
Chilled Grapefruit Sections Wheat Chex — Milk Grilled Ham Slice Buttered Popovers Apple Butter	Blended Fruit Juices Cream of Wheat Cooked in Milk Crisp Bacon Whole Wheat Toast	Grapefruit Sections Raisin Bran — Milk Egg Omelet Hot Biscuits — Butter Jelly	Blended Fruit Juices Hot Oatmeal with Raisins — Milk Buttered Toast Scrambled Egg
Roast Turkey — Giblet Gravy Corn and Tomato Casserole Creamed Asparagus Cranberry Relish Fresh Fruit Cup Lemon Chip Cookies	Baked Ham with Cranberry Orange Sauce* Candied Sweet Potatoes Mixed Greens Corn Sticks Cherry Cobbler Ala Mode	400° Oven Fried Chicken Cream Gravy Fluffy Buttered Rice Scalloped Eggplant Shredded Lettuce with Thousand Island Dressing Bran Muffins — Margarine Prune Cake	Breaded Hamburger Steaks Corn Pudding* Buttered Broccoli Tomato Aspic Salad Orange Cream Sponge
Turkey and Rice Chowder* Toasted Croutons Assorted Cold Cuts Pineapple Chunks with Shredded Cheese Hot Chocolate with Marshmallows	Open-Faced Beef Sandwich Cottage Cheese and Lime Gelatin Salad Baked Apple with Raisin Sauce Milk	Cream of Potato Soup Saltines Ham Salad Sandwiches Assorted Fruit Plate Fruit Sherbet	Macaroni and Cheese with Crisp Bacon Turnip Greens with Roots Glazed Carrots Oatmeal Cookies — Milk

28	29	30	31
Sliced Bananas and Cornflakes — Milk 3 Minute Boiled Egg Crisp Bacon Raisin Toast	Orange Juice Rice Krispies with Milk French Toast Homemade Maple Syrup — Butter Crisp Bacon	Half Broiled Grapefruit Branflakes — Milk Poached Egg on Dry Toast Apple Jelly	Blended Apricot, Pineapple and Grapefruit Juice Hot Oatmeal Cooked in Milk Soft Scrambled Eggs Whole Wheat Toast
Tuna Cheese Puff Buttered Parsleyed Potatoes Buttered Broccoli with Lemon Butter Orange & Grapefruit Salad Strawberry Shortcake	Beef Roast, Natural Gravy Oven Roasted Potatoes Buttered Carrot Slices with Brown Sugar Whole Wheat Bread Berry Cobbler Ala Mode	Pork Chow Mein on Rice Buttered Acorn Squash Chef's Salad with 1000 Island Dressing Herb Buttered French Bread Pineapple and Vanilla Wafer Pudding	Buttered Broiled Fillet of Haddock Tartar Sauce Baked Potato — Butter Buttered Steamed Cabbage Orange-Apple Salad Banana Pudding
Spanish Rice with Bacon Buttered Asparagus Spears Harvard Beets Sliced Banana in Orange Juice Spiced Cup Cake	Cream of Turkey Soup Spiced Ham Sandwiches Apricot and Cottage Cheese Salad Jello Cubes — Oatmeal Cookies Milk	Creamy Potato Soup Deviled Eggs Molded Fruit Medley Salad Lemon Chiffon Pie Milk	Chicken Pot Pie Frozen Broccoli with Cheese Sauce Buttered Mixed Peas & Carrots Shredded Lettuce Salad, Sour Cream Dressing Peanut Butter Cookies — Milk

Recipes for Sample Monthly Menus

BAKED HAM WITH CRANBERRY ORANGE SAUCE

(Yield: 40 to 45 servings)

1 Nine-Pound Canned Ham
1 Pound Brown Sugar
¾ Cup Cornstarch
2 Quarts Cranberry Juice
4 Ounces Frozen Orange Juice Concentrate
3 Cups Orange Section
½ Teaspoon Ginger

Heat ham according to label instructions. Cool slightly. Slice ham and place in steam table pans. Mix brown sugar and cornstarch in sauce pot. Add cranberry juice, orange juice concentrate and ginger. Bring slowly to boiling point and simmer until sauce is clear and thick (about ten minutes), stirring occasionally. Add orange sections. Serve a 1-ounce ladle of sauce over each slice of ham.

TOMATO SUMMER SQUASH

(25 Servings)

5 Pounds Summer Squash (1 Gallon)
2 1/3 Cups Chopped Celery
1 1/4 Quarts Tomato Juice
2 Teaspoons Salt
1/4 Cup Butter or Margarine

Combine all ingredients. Boil gently until vegetables are tender — 20 to 30 minutes.

CREAMED DRIED BEEF

(25 Servings)

1½ Cups Butter or Margaine
1½ Cups All-Purpose Flour
3 Quarts Hot Milk
2½ Pounds Dried Beef
¾ Teaspoons Worcestershire Sauce

Make a white sauce of the fat, flour and milk. Add dried beef and Worcestershire sauce. Serve over rice (cooked without salt), baked potatoes or toast.

CORN PUDDING

(25 Servings)

8 Eggs, Slightly Beaten
2 Cups Evaporated Milk
2 Quarts Cream Style Corn
2 Teaspoons Salt
1 Teaspoon Paprika
1 Quart Celery, Shredded
2 Tablespoons Pimiento, Cut in Pieces (Optional)

Turn on oven and set at moderately slow (350° F.). Mix together slightly beaten eggs, milk, corn, salt, paprika, celery and pimiento. Pour into greased baking pan. Set in pan of hot water. Bake on center shelf of oven for 45 minutes, or until firm. Makes 25 servings of about ½ cup each.

GOOD BUYS*

POULTRY — Turkeys, fryers.

PORK — Hams and picnics, fresh roasts and steaks, sausage.

BEEF — Ground meat, chuck, round steak, stew.

OTHERS — Eggs; lunch meats, liver, franks; tuna, frozen and canned fish and seafoods; dairy foods.

VEGETABLES — Potatoes, collards, turnips, corn, cabbage, field peas, celery, squash, onions, carrots, cauliflower; dried peas, beans, and rice.

FRUITS — Bananas, watermelons, cantaloupes; raisins; canned and frozen fruits and juices.

* In plentiful supply and at prices attractive to food shoppers.

CORNED BEEF AND CABBAGE BAKE

(Yield, 25 one-cup servings)

2 1/4 Pounds Cooked Corned Beef
4 Pounds Coarsely Shredded Green Cabbage
½ Pound Butter or Margarine
1 Cup Flour
1½ Teaspoons Salt
½ Gallon Milk
1½ Quarts Celery, Shredded

Thinly slice the corned beef and cut into 1-inch squares. Cook cabbage and celery in boiling salted water for about 4 minutes. Melt butter and blend in flour and salt. Cook over low heat for about 5 minutes. Add milk and cook, stirring constantly, until sauce is thick or until flour taste has disappeared. Combine corned beef, except for a little to use on top of mixture, cooked cabbage and sauce and mix lightly until ingredients are evently distributed. Pour into oiled 12 by 18 inch steam table pans and bake in preheated 350° F. oven for 20 to 30 minutes. Arrange remaining corned beef on top of vegetables and return to oven for 10 minutes.

TURKEY AND RICE CHOWDER

(25 Servings)

2 Quarts water
2 Cups Rice
3 1/8 Pounds Diced Turkey
1½ Quarts Tomato Juice
3/4 Quart Shredded Carrots
1½ Teaspoons Salt
1 Quart Turkey Broth
¾ Quart Green Peas

Bring water to a boil in stock pot. (Use juice from green peas and enough added water to make two quarts.) Add the rice and all the ingredients except the peas. Cover and cook over a low heat for 25 minutes or until the rice is tender. Add the green peas just before serving time.

PENNY WISE MENUS

BARBECUED TURKEY

Purple Hull Peas — Buttered Corn-on-Cob
Fresh Relish Plate
Hot Buttered French Bread
Vermont's Rice Pudding — Milk — Tea

TURKEY A LA KING ON BISCUITS

Panned Cabbage Deluxe — Escalloped Potatoes
Congealed Peach Salad
Watermelon — Milk — Tea

VERMONT'S RICE PUDDING

1 cup heavy cream
3 cups cooked rice
Maple syrup

Whip cream and fold into cooled rice. (Rice is seasoned with salt, but add no other seasonings.) Chill. Serve in dessert glasses with maple syrup as the sauce. Makes 6 servings.

TURKEY A LA KING ON BISCUITS

6 tbsps. butter or margarine
6 tbsps. flour
½ tsp. salt
1/4 tsp. pepper
1¾ cups broth
2/3 cup cream or whole milk
2 cups cut-up leftover turkey
1/4 cup cut-up pimiento, well drained

Melt butter over low heat. Blend in flour and seasonings. Cook over low heat, stirring until smooth and bubbly. Stir in broth and cream. Bring to boil. Boil 1 minute, stirring constantly. Add turkey and pimiento; heat through. Serve in 8 tart shells, toast cups, or over biscuits.

PANNED CABBAGE DELUXE

1 large onion, sliced
1 tbsp. fat
2 cups shredded cabbage
1 cup grated carrots
1 tsp. salt
1/8 tsp. pepper
1 cup boiled water

Saute' onion in hot fat in heavy skillet until soft and clear. Add cabbage, carrots and seasonings. Pour water over vegetables. Cover, and simmer 12 minutes. Serve hot. Makes 6 servings.

Nursing Schools admit more students in 1960

An estimated 73,565 new students were admitted to schools of professional and practical nursing in the United States during 1960, compared to 71,297 in 1959, Fred C. Foy, chairman, Committee on Careers, National League for Nursing, New York, has announced.

The 1,152 professional nursing programs offered in hospitals, colleges and universities, and junior colleges, admitted 49,787 new students in 1960, an increase of almost 2,000 over the 47,797 who entered in 1959, Mr. Foy stated. Estimated admissions to practical nursing programs for the same period showed a slight increase from 23,500 to 23,778. There were 661 such programs last year, compared to 607 in 1959.

Largest Classes

Among professional nursing schools, diploma programs in hospitals and independent schools continued during 1960, as in the past, to enroll the largest number of new students. Their 39,219 admissions represented 78.7 per cent of the total, marking the first time diploma schools have admitted less than 80 per cent of all professional nursing students. Both baccalaureate and associate degree programs showed a rise from previous years. Colleges and universities admitted 8,424 nursing students, or 17 per cent of the total, to study for bachelors degrees in nursing. Associate degree programs, usually in junior and community colleges, admitted the remaining 2,144 new students, or 4.3 per cent of the whole.

Mr. Foy noted that the ratio of professional nurses employed full time in the country in 1960 — 231 per 100,000 population — is still far short of the 300 per 100,000 considered a minimum goal. The overall figure for 1960 was 504,000 employed professional nurses, some 90,000 of whom were working part time. There are over 220,000 licensed practical nurses in the country.

To meet the need for more nurses, the capacities of nursing schools, now at near quota enrollments, must be expanded, Mr. Foy continued. This means not only an increase and/or enlargement in schools, but also more qualified teachers. There were, for example, 1,188 budgeted vacancies in nurse faculty posts on January 1, 1960.

Statistics Gathered

Statistics on nursing education are gathered annually by the National League for Nursing through questionnaire surveys to all state-approved schools of nursing in the country.

Mr. Foy, chairman of the board, Koppers Company, Pittsburgh, serves as volunteer chairman of the Committee on Careers, which conducts a national information and guidance program on career opportunities in professional and practical nursing as part of the League's program to improve nursing service and nursing education. The Committee is co-sponsored also by the American Hospital Association, the American Medical Association, and the American Nurses' Association.

OUR PRAYER

God, give me EYES that I might see
The work that can be done by me.
God, give me EARS that I may hear
The cries of those that need me near.
God, give me LIPS that I might speak
Comfort and peace to all who seek.
God, give me a MIND that I might know
To help the ones that need me so.
God, give me HANDS that I might do
Some large or simple task for You.
God, give me Prayer, that I may pray
For help and guidance every day.
And these things all else above —
God, give me a HEART that I might Love.

From Arizona Association of Nursing Homes.

PATRONIZE YOUR ADVERTISERS & EXHIBITORS

(con't. from page 14)

as an emotional argument. We see no way to avoid them.

The English System

I am sure that everyone who has traveled in England has come back with his own ideas about the English system. I will only say about mine, a conversation I had with an English industrialist when he was bemoaning the English program. I asked "How do you get out of this?" He replied, "Oh, that's easy. How do you unscramble eggs?"

Now let's look briefly at the present bill. I think that one would have to concede that it is a fairly good bill as it is drawn. It is ironical, I think however, that the advocates of Social Security have used as one of their main arguments that this will eliminate the "indignities of a degrading means test".

In my opinion, the $90.00 deductible is a means test. Actually, all that is done is to transfer the screening job with the resultant criticism from the government to hospitals. If the government is not able, through the taxation of over 75 million people, to pick up this tab, I ask you in all sincerity, how can the voluntary hospitals afford this cost? Certainly this provision is a means test.

In addition, I have great concern over the interpretation which may be placed on the provision that the government will pay "reasonable costs" to hospitals. I fear that any payment less than real cost will undermine the financial stability of the voluntary hospitals of the nation. I think it is unnecessary to say that if the voluntary hospitals of this nation were to become financially insolvent, then federal medicine, which would far exceed a compulsory health insurance program would follow.

I think it is most unfortunate that the aged of our population have been led to believe that health care under Social Security is a panacea. Actually, the long-term patient who needs the care the most and has the greatest expense, has been only partially covered by any bill that has been seriously considered. But I am not arguing that the program should be enlarged. I am saying that I think the public is entitled to know the facts. I think if they knew the facts, a program using Social Security taxing mechanisms would have much less political appeal.

Recently, Senator Goldwater pointed out the cost of federal government administration by illustrating in the State of New Jersey it takes $1.47 in tax funds sent to Washington to produce one dollar's worth of benefits when returned to New Jersey. The Senator also pointed out that 30 percent of our national income, our total gross income, now goes to the government in the form of taxation.

About Social Security

I would like to show you one thing in reference to Social Security. At the present time, the Social Security program, as it now stands, provides for a tax on employees and employers of 6 per cent. This will increase during the 60's to 9 per cent, without additional program. The one-half of one per cent advocated for health care of the aged is based on approximately one billion dollars annual expense.

The insurance industry's estimate, according to Ardell T. Everett, Secondary Vice President of the Prudential Insurance Company, is that the first year cost will range from 2 to 2.4 billion and that in less than two decades, this will have increased to 6 to 7.6 billion in terms of the 1960 dollars. Projecting this further would mean that by the end of this decade, the Social Security tax would need to be 12 percent of the nation's payroll, without any further additions to the program.

I think one should be very apprehensive about the effect of further burdening of the Social Security program on the financial stability of our nation. Maurice Stans, Director of the Bureau of Budget, is quoted in the New York Times, December 2, 1959, as making this statement: "Including the national debt the financing of previous legislated governmental programs, but exclusive of Social Security, the taxpayers are confronted with an obligation of 750 billion dollars."

Has Lost Money

We all know that Social Security has lost money for three years and, therefore, adding the Social Security liability to the previously cited obligations of the American taxpayers, we are confronted with the tremendous sum of one trillion one hundred billion dollars. This is equal to thirteen years of total federal income.

The point to which I am directing my remarks is the fear that placing any part of health care under Social Security would ultimately do one or both of two things; first, further jeopardize the financial integrity of Social Security and possibly the entire nation. And I think I am speaking as an American citizen, rather than as a hospital administrator.

Secondly, add further taxation on our people.

It is also significant to me that many of the advocates of Social Security have also now embraced the Kerr-Mills bill. Thus, we will need two programs.

In conclusion let me mention that a report from the World Health Organization indicates that while the life expectancy for the world as a whole is 40 years, in the United States, it is 70 years. Let me emphasize this, that my point is that it is not a condemnation of a society that it has a large group of aged. Rather, I think it is a tribute to the system of medicine which has produced such a result and therefore, I would be opposed to anything that would alter or destroy a system which by all comparisons has been eminently successful in furnishing health care to the population for which it is responsible.

Lenin, the architect of Communism said: "Compulsory health insurance is the keystone to the arch of the socialistic state."

One word in conclusion and in admonition. That is—don't scramble the eggs.

MALPRACTICE (con't. from page 9)

Programs Established: More than half the state medical societies have offered malpractice claims prevention programs, and county medical societies are supplementing this effort, said Dr. Sadusk. However, he thinks that "we have barely scraped the surface of malpractice prevention and education."

Programs designed to secure expert medical advice or testimony for the malpractice plaintiff have been established in many major metropolitan areas, including Los Angeles, San Diego and San Francisco in his own state, said Dr. Sadusk. Such a program for the Oakland-Berkeley area is to be set up before the end of the year, he said.

"What may work in one community will not in another," said Dr. Sadusk, "As a result, I believe that we shall eventually see a variety of methods used throughout the United States. That the plans may be different is not of importance; but that the plans will work to serve justice is important."

Application of Closed System Injection and Blood Sampling Units

By KENNETH R. NELSON, JR., M.S.

Editor's Note: The author of this interesting article, Mr. Kenneth Nelson, is familiar to Nursing Homes readers.

This work concerned itself primarily with nursing homes and physicians, and was presented to the Pharmacy Section of the annual meetings, American Association for the Advancement of Science, December, 1959.

Mr. Nelson is Consultant in Administrative management of Medical Care Facilities, Nursing Home Services Section, Chronic Disease Program, Division of Special Health Services, Bureau of State Services, Public Health Service, U. S. Department of Health, Education, and Welfare.

Considerable time and effort have been spent on evaluating the use of disposable syringes and syringe-needle combinations in the general hospital. Most of these evaluations have concerned themselves primarily with the comparative costs of using the disposable and nondisposable equipment. Very few studies have dealt with the intrinsic worth of disposables or their use in programs outside the general hospital.

Any disposable product has a number of labor-saving features. The closed system type of disposable, however, provides additional advantages that might make such units particularly adaptable for use in the nursing home and by the private practitioner. For this reason it was decided to conduct a limited study to ascertain to what extent disposable syringes and syringe-needle combinations might benefit the nursing home and the private physician.

Nursing Home Study

A completely "closed system" was used to administer parenteral medications and fluids and to collect blood samples. In the case of injectable units, the closed system involved sterile, prefilled, disposable cartridge — needle combinations or sterile, prefilled, disposable syringes. For the collecting of blood, sterile, disposable, evacuated blood-collecting tubes and needles were employed. These systems are called "closed" because their use requires no transfer of medication or of blood sample and no resterilization of needles or syringes.

Originally it was hoped that it might be possible to develop a series of time study tables for nursing homes similar to tables elaborated for the study conducted at the U. S. Public Health Service Hospital, Baltimore, Maryland, by Dr. James Hunter[1] and associates. However, it became obvious after preliminary discussion with the administrators of the two nursing homes participating in the study that the development of such charts would be impractical if not impossible since the homes had neither a central supply department nor a pharmacy. Accordingly, time studies (*tables* 1 *and* 2) were conducted that dealt only with the nursing time involved in the giving of an injection by the closed system and by the conventional system and similarly comparing the drawing of blood samples by the closed system and the conventional system.

The average time in seconds (*table* 1) it took to complete each injectable operation was based on 10 injections in each home. There was only slight variation in the timings made in the two homes. The results contained in these tables are quite similar to those obtained in studies conducted at the Jefferson Hospital of Philadelphia[2] and the U. S. Public Health Service Hospital, Baltimore, Md.

Special attention is called to the time it took to administer injections of Sparine Hydrocholoride* (promazine hydrochloride). This time is usually high because the medication was administered to slightly disturbed patients. These patients had to be held while the injection was given. The difference in time between the two systems could be due to the fact that the nurse laid the conventional syringe down while preparing the patient and hence had to pick it up again to give the injection. In contrast, she held the cartridge syringe in her hand during the entire procedure.

The average time in seconds (*table* 2) it took to draw a blood sample by the conventional and by the evacuated tube system was based on seven samples. It is realized that they are by no means conclusive since sampling errors may be large, due to the small number of observations. They do indicate, however, that a time saving can be realized by using the evacuated collecting tube.

It should be noted that no time for the sterlizing operation is included in this table. Sterlization of the needles and syringes used in the conventional system in these particular homes was done centrally, and the nurse doing this work was unable to give a reliable estimate as to the time involved in this procedure. She indicated, however, that it took her about five minutes per syringe and needle to perpare them for autoclaving, and to get them ready for distribution to the floor after autoclaving.

Advantages

The time needed to draw a blood sample or make an injection by the closed system is approximately half the time needed under the conventional system.

While the time saved appears to be significant, it cannot be considered as important to the nursing home as it is to the hospital. Nursing homes do not administer as many injections to their patients as do hospitals. The average 25-bed nursing home administers somewhere between five and ten injections a day and draws about five

blood samples every other day. The so-called intangible features of the closed system are the ones that have the most significant application to nursing homes. These features can be divided into three basic categories: sterility; accuracy; facility.

Sterility

The sterlization of supplies poses a considerable problem to most nursing homes. Not enough needles, syringes, catheters, and other medical equipment are used to warrant the installation of autoclaves or any of the other specialized sterlizing equipment commonly found in the general hospital. The average nursing home has to rely on small sterilizers which operate on the boiling principle; these need continual and careful cleaning and maintenance. Since closed system units are sterile when used, they require no special equipment for routine sterlization of syringes and needles.

Nursing homes continually strive to maintain their instruments and supplies in top condition. This is often difficult, since many of their employees are not adequately trained. Such people tend to be careless in handling needles and syringes. Needles become blunted and syringes broken. A blunted needle is an even more serious problem in a nursing home than it is in a hospital because of the age and physical condition of the patients being cared for. The older individual usually has tough, leathery skin which makes it difficult to give injections or draw blood samples under the best of circumstances. This is undoubtedly the reason why many nursing homes tend to prefer oral to injectable dosage forms. Use of the disposable, closed unit, with its sterile, sharp needle, can be of distinct advantage under these conditions.

Because there is a shortage of professional nursing personnel, many nursing homes must rely on practical nurses and nursing aides to provide much of the patient care. These individuals are often called upon to administer injectable medications and to draw blood samples. It is obvious that the use of semi-professional personnel, in situations calling for professional skills, can result in great danger to the patient. Closed system units can minimize such danger by eliminating many possible sources of error.

Where injectable dosage forms are called for, the cartridge or prefilled disposable syringe guarantees that the prescribed amount of medication is available for instant use and in the correct dosage. There is no possibility of error in calculation or in filling; the patient receives the prescribed dosage.

Drawing of blood can be greatly simplified and the dangers to the patient minimized with the use of the evacuated blood collecting tube. This system assures that only the desired amount of blood is withdrawn and that the blood is immediately mixed with the correct amount of necessary anticoagulant. Thus, one simple unit can help to obtain a sterile, correctly prepared and adequate blood sample.

Table 1. Comparative Nursing Time (in seconds) per Injection

	Conventional Method		Closed Method	
	Sparine*	Penicillin	Sparine*	Penicillin
Number of Injections Observer	10	10	10	10
Sterlizing syringe and needle	183.5	183.2	none	none
Obtaining medication from cabinet	26.4	23.2	21.5	20.3
Preparing medication at nursing station	42.7	47.5	31.2	30.8
Preparing patient and administering medication	64.9	18.5	30.1	18.2
Disassembling and rinsing syringe	17.1	27.0	11.2	11.0
Recording administration	25.0	23.8	25.0	23.8
Going to and from patient's bedside	31.8	31.8	31.8	31.8
Total average time per injection	391.4	355.0	150.8	125.7

*Sparine was used on disturbed patients.

Table 2. Comparative Nursing Time (in seconds) per Blood Sample

	Conventional	Evacuated Collecting Tube
Total sample studies	4	3
Preparation of arm	8.5	8.6
Preparation of syringe or unit	30.1	24.1
Selection of vein and puncture	27.5*	19.2
Withdrawing sample	27.6	23.3
Transferring sample to container	20.1	none
Labelling	17.0	6.3
Disassembling and rinsing	36.2	2.3
Total average time per sample	166.9	83.8

*This includes time lost in 2 vein collapses.

Saves on Drugs

The average nursing home does not have a pharmacy and it often does not employ the services of a consultant pharmacist. Pharmaceuticals must therefore be purchased on an individual prescription basis. This means that any unused injectable drugs purchased for a discharged or deceased patient must either be returned to the State agency or destroyed, causing unnecessary expense for the home or the patient and his family. Unused doses in closed system units remain sterile and identifiable. There are no unused portions as in multiple dose vials. State laws permitting, unused quantities of drugs in closed system units may be returned for credit to the pharmacy or company from which they were bought. In this manner, unnecessary expenses for unused drugs can be avoided.

The guaranteed sterility of the needle and syringe of closed system units was mentioned previously as a feature that might provide an advantage to a nursing home. In addition, the sterility of the drug product must be considered as well. Once the seal of a multidose container has been broken, the contents of that container can no longer be considered 100 percent sterile. With each subsequent dose withdrawn, there is the possibility that the infection of a previous patient will be transmitted to the patient receiving the medication.

In a recent article, Doctors T. Gibsen and W. Morris[3] reported that there are strong indications that small skin plugs are removed each

time an injection is made. Their studies reported that out of 300 stabs, 69 percent (207) removed visible skin plugs. They were unable to predict what happened to such plugs but indicated that they may be either injected into the blood stream, aspirated back into the syringe or that they adhered to the rough inner surface of the needle. If the plug is aspirated into the syringe or "hung up in the needle," there is a strong possibility that it will remain there, even after careful cleaning, to be injected into a vial or the blood stream at a later date. Single dose, closed system units eliminate most of these hazards.

Most nursing homes have very little storage or nursing workspace. Therefore, another advantage of closed system units is their relative compactness. They require no separate storage space for syringes and needles.

Offsetting these advantages is the possible higher cost of the closed units which has been the topic of considerable controversy. It has been shown that if depreciation, labor, and other costs are considered, the closed system units cost only a small additional fraction of a cent more per puncture. Under some conditions, the cost may be lower than that of the conventional system. In many cases this slight increase in cost can be incorporated in the charge made for the medication or the laboratory test with little additional burden to the patient.

Saves Time

Reduction in the time the physician must spend on tedious routine means a corresponding increase in the time he can devote to the patient. A saving of only three to five minutes per office visit or house call results in an over-all saving of from one to two hours a day. Any physician would welcome this extra time available for his practice.

Several physicians were interviewed to determine what they considered the advantages of the single dose, closed system units. An extremely busy internist pointed to a small case on a table in his office. "That" he said, "is my bag. I used to carry a much larger bag equipped with the usual number of sterile syringes and needle containers and the usual number of bottles and other paraphernalia. Now I only need closed system units and their holders."

The availability of a guaranteed sterile unit held great appeal to all physicians interviewed. Many said that although they took all precautions in sterilizing, they sometimes had some misgivings when using the conventional syringe. One physician who treats primarily aged patients feels this to be one of the most valuable aspects of the closed emergency situation where a sterile syringe is needed immediately. With closed system units, this is at hand. With conventional units, he would have to take time to sterilize. In such situations a difference of three or four minutes may mean the patient's life.

A physician with a large rural practice commented that he liked the convenience of closed system blood collecting units. He can draw a blood sample, place it in a mailing tube and mail it to his laboratory.

With the prefilled unit, it is impossible to give overdoses through miscalculation. The patient's family, with minimal training, can be taught to administer certain injectable drugs, thus saving the doctor a needless house call to simply make an injection.

The doctors emphasized that patients were generally impressed with closed system units. The assurance of a sharp needle appealed to patients, as did the idea that he had his own syringe. The firmly attached needle also appealed to some of the physicians since it could not become detached.

The consensus of the physicians interviewed was that closed system units were highly practical and very valuable. They felt that, both to them and to their patients, the slightly higher original cost of such units was more than counterbalanced by the advantages.

Also available at the present time are all glass disposable syringes and blank cartridges for cartridge syringes. These glass units should not be confused with some plastic counterparts which may react with a few chemicals contained in some medications, most notable being paraldehyde.

The glass disposable units embody many of the same advantages of the closed system units and form a valuable adjunct to them. They can be used for those medications that are not prepackaged and for those procedures that do not adapt themselves readily to closed system techniques.

The advantages of "closed system" units reach their greatest potential when these units are used in conjunction with other sterile disposable items. Whether any increased cost, if it exists, offsets the safety and patient satisfaction embodied in the units is a matter for personal evaluation. It is my belief that the advantages are worth the extra cost, if any, and that the future will see an increasing use of such units in all phases of medical care.

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[1]Hunter, J. A. et al.: Hospital medication injection costs; a preliminary study. Hospital Management 81:82-86 (March), 1956, 81:80-84 (April), 1956, 83:86-96 (March) 1957.

[2]Bourn, I. F., Flack, H. L., and Browneller, E.: Hospital pharmacy preparation of disposable unit injections, Bull. Parenteral Drug Assoc. 12: 8-16 (Jan.-Feb.) 1958.

[3]Gibsen, T., and Morris, W.: Excision of skin fragments by injection needles. Lancet 2:983 (Nov.) 1958.

*Wyeth Laboratories, Philadelphia, Pa.

The cooperation of the following companies who furnished the nesessary supplies for this study is gratefully acknowledged: Abbott Laboratories: Manufacturers of Abbiject Penicillin; Becton and Dickinson Co.: Manufacturers of Vacutainer and Hypak Syringes; Wyeth Laboratories: Manufacturers of Tubex.

The cooperation of LeDiieu Gardens Nursing Home, Kensington, Md.; Vinnabona Nursing Home, Braddock Heights, Md.; Dr. Tribbedeau, Dr. H. F. Fahrney, and Dr. Stephen Jones, who cooperated in the necessary research for this study is also gratefully acknowledged. Without their aid the study would not have been possible.

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CHARLES A. MOSHER

CAPITOL ECHOES

What Congress Lacks – THE WILL TO SAY "NO"

By CHARLES A. MOSHER (R), Representative to U. S. Congress — 13th District, Ohio

SO MANY ask, "How do you like Washington? How goes it in Congress?" My quick reply has often been, "I'm not sure yet. I'm confused." And some smile at that. But it is not a facetious reply; it is a simple, serious truth.

How can anyone be sure about the U. S. Congress? Least of all a first term, minority member! My own doubts have increased during these first six months.

> WASHINGTON itself, I like. I can understand "Potomac Fever," the urge to stay here forever. There are some disagreeable contradictions and contrasts. Traffic can be frustrating, living costs are high, the climate is not ideal. But in most ways this is a wonderfully beautiful, fascinating place to live and work. And friendly, too. Everyone, all up the line to the White House, I have found completely, graciously helpful.

WHY then am I uneasy, pessimistic, doubtful that Washington can deal wisely and effectively with the increasing, and increasingly difficult burdens of the federal government?

I tend constantly to measure my new experiences here against 15 years in government at the state and local levels. In the State House at Columbus and in the Oberlin City Council we were required by the Ohio Constitution, and by custom, to have the necessary funds in hand or in sight, before appropriations were voted. It is very difficult in Ohio for the state or local governments to go into debt; all public borrowing must be funded; increased expenditures must be covered by increased tax revenues. Moreover, no statute or appropriation is approved in Columbus (nor, presumably, at any of the lower levels of government in Ohio) without the affirmative vote of a constitutional majority of the legislators, on a publicly recorded roll call. Thus in Ohio (though probably not so in all states) fiscal responsibility and voting responsibility are practically mandatory.

Not so at the federal level! For example, the "ceiling" on public debt, which Congress changes every year or so, is a useless fiction.

> WHEN we voted on June 26 to increase the federal debt limit "temporarily" from $285 billion to $298 billion, it seemed to me the many hours of unctuous debate was largely ridiculous. Debaters wrapped themselves in the robes of "responsible government," but it seemed only a charade.
>
> The added billions were already committed. The bills had to be paid. Technically, it was essential that we raise the debt limit. But I voted against that raise, as a matter of protest. (During my campaign for election, I promised to vote for tax increases rather than deficit spending, when faced with those alternatives.)

THAT same day, without a roll call, without debate and in the first fifteen minutes of the session while few members were on the floor, six other measures were gavelled through the House. At least two of those six were extremely

important and debatable, having to do with constitutional rights. Even though they applied only to the District of Columbia, their implications were very broad; it seemed to me they deserved even more attention than we gave to that phony "debt limit." And that same week there was debate, and a roll call vote on the silly proposal to create a special flag for congressmen to fly on their boats or automobiles!

Is Congressional Voting Too Frivolous?

Those few examples indicate why a newcomer may feel that the House is too frivolous in its voting habits. Frequently, measures involving important policy questions and billions of dollars are approved merely by voice vote, so no member is placed on record and held accountable for his "Aye" or "Nay". Or, frequently, when we do have a roll call vote, it is on a so-called "omnibus" bill, so big and complicated, so full of both good and bad, that a simple "Yea" or "Nay" is in effect frivolous.

NOTE again the contrast: Fiscal responsibility is practically forced upon state and local legislators (in Ohio at least). But Congress is limited only by its own self restraint, in fiscal decisions.

ARE we in Congress exerting self restraint, are we providing for payment of the billions in new obligations we are voting? No, so far as I can see; except by increased borrowing, increased greenbacking . . . which simply means higher living costs for everyone, a subtle means of taxation which hurts the most those who are least able to pay. Is that a wise or responsible procedure?

More Responsive Than Responsible

I believe mine is a valid complaint, that Congress tends to be more responsive than responsible. In response to almost any cry for help, Congress too easily and willingly reaches down to lift up and carry on forever, and expand, whatever services the state and local governments find difficult to carry. And Congress does this with so little concern for the costs. Washington is all too willing!

Is not the federal government already too unwieldy, too bogged down? Is not the span of responsibility already too broad and varied for the White House and Congress to handle effectively?

WILL NOT the creation or expansion of new federal agencies . . . to assist the cities, or school districts, or whatever . . . merely dilute and impede that much more the capabilities of Congress and the White House to accomplish their primarily important federal tasks effectively?

I SEE no men here who stand so extraordinarily tall. Members of Congress are for the most part able and conscientious, but not more so than members of the Ohio General Assembly or Oberlin's city and school officials. Congressmen differ only in these ways: 1 — They control the federal government's vast taxing and credit creating authority; thus they have easy access to seemingly limitless "easy money". 2 — They are full time, professional politicians, of necessity much more concerned about getting reelected than are most of the part time "citizen legislators" at the state and local levels.

It is easy to see then why Congress is under increasing pressure to supply more and more money for state and local services, why Congress more and more accedes to such pressures, and why each new or increased appropriation here only encourages the pressure for still more.

But I see no reason to believe that is good for Congress or good for the country, its long term results. Congressional appropriations for any function . . . for instance, public education . . . inevitably will be followed by increasing Congressional oversight (or harrassment?) of that function, and I see no reason to believe that is good . . . not good for the schools, for instance. There is nothing in the sprawling, tangled, easy come-easy go ways of big, BIG government, as I see it here in Washington, to bolster my confidence that its decisions are wiser than those made at the local levels.

Needed, The Will To Say "NO"

I believe it is a vain thing to believe centralized government, even with all its extraordinary money resources and power, can do wisely and well so much for so many. The most important lack I see in Congress is its lack of the will to say "NO". It is too easy for Congress to say "Yes", to the requests for it to take over wherever the state services are inadequate.

True, it will be extremely difficult to reorganize state and local governments (especially tax structures), to provide them the means and capacity for supplying adequate services at those levels. But that is where it could and should be done. Perhaps Congress might force the needed renaissance in state government, if only it could firmly say "No, No, No!"

Montgomery County Program for Occupational Therapy Assistants in Geriatics and Long Illness

VIRGINIA LOUISE CASKEY, O.T.R.
Administrative Director

". . . Foremost among my sharpest impressions as a patient in a nursing home was the unnecessary unhappiness caused by unrelieved idleness – the lack of even the simple occupational therapy and the consequent depression and discouragement of the long, empty days. As I saw this condition, I became convinced that it was not only the cause of unnecessary suffering, but was a deterrent of physical improvement.

". . . Fortunately for myself I was able to read and did not face the problems of those around me, who constantly asked me to tell them about what I was reading. It was in these little daily chats during which I tried to pass on a little of my own entertainment, that I came to know intimately the tragedy of lonely old age and to understand their plight as they faced the loss of ties with active life and the burden of idle days.

"And so I am hoping to hear more of what I am told is a practice in some of the care homes, of providing something for their patients to do.

Easy Occupations

"For those, however old and ailing, there are easy and simple occupations, either followed alone, or better still as a group project, which according to all authorities on this work, results in happy and new relationships and often general improvement.

"We talk much today about 'inalienable rights.' I think the old, the dependent, the lonely, those so easily forgotten, have an inalienable right to those things that make the difference between a contented and peaceful waiting and hopeless resignation."

Several years ago the letter from which the above quotations were excerpted reached the desk of the International Program Coordinator of Montgomery County, Maryland. This letter touched off a response which was to have far reaching effects.

Under the stimulus of the Coordinator's efforts, District No. 2, Maryland Nursing Home Association organized workshops for nursing home administrators to ascertain what contribution occupational therapy might make to the nursing home patient and how occupational therapy might be included in existing nursing home services. The concensus of the workshops was that organized activity, mental or physical could contribute greatly in maintaining function, preserving morale and reducing patients' fear of activity. Occupational therapy was regarded as important to the patient both physically and emotionally.

Pilot Program

A nursing home whose medical leadership expressed great interest was selected for a pilot program with a registered occupational therapist from Montgomery County Tuberculosis and Heart Association. Experience in this endeavor indicated that in order to meet the needs of a significant number of patients more manpower was needed. It was felt that nursing home personnel might be able to carry out organized activities under the supervision and guidance of a registered occupational therapist.

Two nursing homes designated employees to be responsible for such a program in consultation with and under the supervision of the registered therapist. In the plan which was developed results were gratifying. Patients whose disabilities limited their participation in physical activity found outlets in group discussions, in planning and in suggestions concerning the projects of others. Patients who had seldom spoken became vociferous when decisions were being made by the group.

Nursing home personnel witnessed increased interest and awareness on the part of the patients as well as greater responsibility for self care. A patient who for over seven years had been dressed by personnel now dressed himself. Families were amazed by the achievements of patients who for years had done nothing. Physicians indicated approval of the program through additional referrals to the service. -Experience demonstrated that in addition to increasing self care, activity programs encouraged patients who were able to be up and out of bed. It was hoped that the decreased need for personal care would reduce the number of personnel needed for this type of service to patients; that occupational therapy would increase the quality of services to patients without increasing the cost of patient care.

An Outgrowth of Effort

The Montgomery County Program for Occupational Therapy Assistants in Geriatrics and Long Term Illness was the outgrowth of these preliminary efforts. A representative of the American Occupational Therapy Association's Committee on Occupational Therapy Assistants was consulted in an advisory capacity and steps were taken to secure a research grant for a training program.

Specifically, the proposal was for a demonstration program which would train occupational therapy assistants and evaluate their effectiveness in providing occupational therapy in nursing homes under the supervision of a registered occupational therapist.

Supported by the interest and participation of an impressive list of organizations including Montgomery County's Health Department and Board of Education, Montgomery County Medical Association, Maryland State Department of Health, Maryland District No. 2 Nursing Home Association, Maryland and District of Columbia Occupational Therapy Associations, U. S. Public Health Service–Behavioral Studies Section, the Physical Medicine and Rehabilitation Service of Washington Sanitarium and Hospital and with matching funds from the American Heart Association, the Maryland Heart Association and

Montgomery County Tuberculosis and Heart Association, the project received on May 25, 1960, a three-year grant from the Office of Vocational Rehabilitation, U.S. Department of Health, Education and Welfare, to be administered by the Montgomery County Health Officer.

Four committees were formed to act in an advisory capacity to the project.

The Advisory Committee has been concerned with recommendations that concern the broad, over-all aspects of the program and with coordinating the efforts of three other committees.

The Curriculum Committee established standards for selection of students and for centers for supervised application of occupational therapy in field training. It approves the lecturers and other part-time personnel and has assisted in developing an acceptable curriculum for the training program.

Three Phases Involved

The Evaluation Committee is concerned with three phases of the program.

A. Evaluation of the quality of education and clinical experience which the students receive. This evaluation is accomplished through various quizzes and evaluations given the students during the training course and through approval of the program by the American Occupational Therapy Association.

B. The second phase of the work of the Evaluation Committee is carried out within the nursing homes selected as centers for practical experience. A medical team, with the prior approval of the patient's own physician, evaluates the patient's mental and emotional potential and recommends appropriate occupational therapy. The team includes a psychiatrist, a registered nurse, the nursing home administrator or his representative, and a registered occupational therapist. A few evaluations are made before the students begin their practical experience period in the nursing home. Subsequent evaluations are made with the students present to participate and observe the procedure. Reevaluations are made from time to time with the students as a check on the effectiveness of their treatment or the need for changes in treatment.

C. The third phase of evaluation will be an effort to determine the effectiveness of the graduate occupational therapy assistants in providing occupational therapy in the nursing homes where they are employed. This evaluation will be keyed to the goals and purposes of the training program as defined by the Curriculum Committee.

The membership of these committees includes physicians, nurses, nursing home administrators, educators, physiatrists, psychiatrists, psychologists, vocational counselors, occupational and physical therapists and representatives from the allied disciplines of the sponsoring groups.

A supervising occupational therapist for the program was employed on July 20, 1960, a coordinator and director were employed on October 24, 1960, a full time secretary was added to the staff on December 21, 1960.

The services of other occupational therapists have been utilized on a part time basis for instruction and supervision of students. It has been determined that additional full time occupational therapists will be needed for subsequent teaching programs and for supervision as more graduates of the course are employed in nursing homes. In addition to the regular staff a number of lectures in medicine and allied fields present the required academic work for the program.

The three-months program includes over 400 hours of class room work and supervised practical experience in nursing homes and hospitals to meet the essentials of the program for occupational therapy assistants in general practice as outlined by the American Occupational Therapy Association.

Subject matter covers understanding the nursing home patient and his problems, nursing home services, personality development, clinical conditions encountered in the nursing home, rehabilitation concepts, medical terminology, psychology, history and philosphy of occupational therapy, application of occupational therapy, principles and techniques to specific clinical conditions, hand crafts, recreational and group activity and instruction in self care (activities of daily living).

The Montgomery County Program is the first program of its kind anywhere. It is the first class for occupational therapy assistants in general practice established under standards set up by the American Occupational Therapy Association in October, 1960. It is also the first program geared toward nursing home patients.

Twelve Graduates

The twelve graduates of the first class who completed their training on June 1, 1961, are now being employed in nursing homes where they are setting up occupational therapists on the training program staff. It is stipulated that occupational therapy assistants must work under supervision of a registered occupational therapist. This obligates the program to provide continued professional job supervision, seminars and workshops for the graduates. Indications are that this group and subsequent graduates of the program will help to meet a longfelt need in nursing home care and will help to make a difference in the "unrelieved idleness" and "hopeless resignation" described by the author of the letter which set the wheels in motion for this program.

Artificial Hip Recommended for Fractures in Aged

The use of artificial hip joints for elderly persons who suffer severe hip fractures was recommended recently by three Cleveland physicians.

The operation allows the patient to bear weight on the hip in two to three weeks, according to Drs. J. George Furcy, George E. Spencer, Jr. and Donald J. Pierce.

Other surgical procedures, in which the broken hip is set and allowed to heal, require the patient to avoid weight bearing for six months.

Writing in the (July 15) Journal of the American Medical Association, the authors conceded that "the end result of a well-healed hip fracture is superior to the average prosthesis result."

Non-weight bearing

However, if healing can be expected in only 65 to 75 per cent of the cases and complications can be expected in 20 to 40 per cent of those cases, then patients over 70 years of age or younger patients with severe physical or mental disabilities should not be subjected to the extended period of non-weight bearing required for healing, they said.

When an elderly or debilitated person sustains a hip fracture, it frequently marks the beginning of a gradual or rapid deterioration, they commented. A six-months' convalescence in many elderly patients precludes any significant degree of walking, which by itself causes complications and necessitates considerable nursing care, they said.

This discouraging picture can, for the most part, be avoided with the insertion of an artificial hip joint, they said.

These patients can get out of bed the day after surgery and walk with full weight bearing as early as two or three weeks after the operation when there is healing and recovery of sufficient muscle strength, the physicians said.

The rapid return to near prefracture state of physical activity prevents many of the general complications commonly encountered following hip fractures, they said.

It is knob-like

The prosthesis consists of a knob, replacing the ball-like end of the thigh bone which fits into the pelvic socket, and a stem which fits into the thigh bone.

The authors reported on a study of 102 patients with an average age of 74, who were operated on during a five-year period.

Of the 102 patients, excellent or good results were obtained in 82 per cent, they said.

This was felt to be "very satisfactory considering the difficult problem at hand," and that almost half of the operations were performed after failure of an initial bone-setting operation or as a result of a late complication, they said.

The authors said they also felt that the operation is "not unduly hazardous" in the aged.

Calendar of Events

Oct., 2-6, 1961 — American Nursing Home Association annual convention — Pick-Carter Hotel, Cleveland, Ohio.

Oct. 9-12, 1961 — American Association of Medical Record Librarians, Benjamin Franklin Hotel, Philadelphia, Penna.

Oct. 16-19, 1961 — American Dental Association, Sheraton Hotel and Convention Hall, Philadelphia, Pa.

Oct., 16-17, 1961 — Licensed Nursing Home Association of New Jersey, Inc. Convention, Traymore Hotel, Atlantic City, N. J.

Oct., 24-25, 1961 — Iowa Nursing Home Association Convention, Hotel Kirkwood, Des Moines, Iowa.

Oct. 24-27, 1961 — American Dietetic Association, Jefferson-Sheraton Hotel and Kiel Auditorium, St. Louis, Missouri.

Oct. 29 - Nov. 1, 1961 — Pennsylvania Ass'n. of Nursing and Convalescent Homes Convention, Pocono Manor Hotel, Pocono Manor, Pennsylvania.

Nov. 1, 1961 — New Hampshire Association of Licensed Nursing Homes 12th Annual Conference, New Hampshire Highway Hotel, Concord, New Hampshire.

Nov. 5-11, 1961 — American Occupational Therapy Association, Detroit, Mich.

Nov. 7-10, 1961 — California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged — Annual Convention, Disneyland Hotel, Anaheim, Calif.

Nov. 7-9, 1961 — Texas Nursing Home Association annual convention, Shamrock Hotel, Houston, Texas.

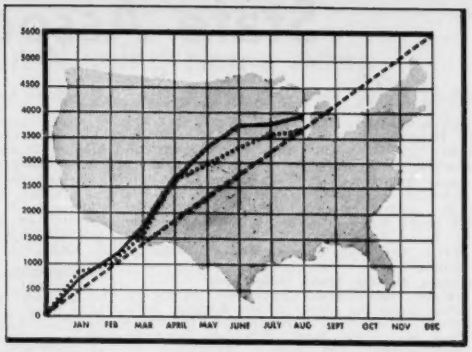
Nov. 7-9, 1961 — Annual Convention of California Association of Nursing Homes, Sanitariums, Rest Homes and Homes for the Aged, Ambassador Hotel, Los Angeles, Calif.

Nov. 16-17, 1961 — Kansas Nursing Home Association Convention, Warren Hotel, McPherson, Kansas.

Nov. 29-Dec. 2, 1961 — APWA'S National Biennial Round Table Conference, Edgewater Beach Hotel, Chicago, Illinois.

The Scoreboard . . .

SOLID LINE—1961 Membership
DOTTED LINE—1960 Membership
BROKEN LINE—1961 Quota



I. Twenty-eight states have reached or exceeded their 1960 total memberships:

Arkansas	Nevada
Delaware	New Mexico
Florida	North Dakota
Georgia	Oklahoma
Iowa	Pennsylvania
Kansas	Rhode Island
Kentucky	South Carolina
Louisiana	South Dakota
Maine	Texas
Minnesota	Utah
Mississippi	Vermont
Missouri	Virginia
Montana	Washington
Nebraska	Wyoming

II. Twenty-two states have reached 75% or more of their 1961 quotas:

1. New Mexico 133%
2. Oklahoma 126%
3. Louisiana 122%
4. Wyoming 115%
5. Rhode Island 104%
6. Nebraska 102%
7. North Dakota 100%
8. Florida 96%
9. New Hampshire 95%
10. Kentucky 94%
11. Maine 90%
12. Kansas 89%
13. Tennessee 89%
14. Delaware 88%
15. Washington 87%
16. California 85%
17. South Carolina 84%
18. Arkansas 80%
19. South Dakota 78%
20. Wisconsin 77%
21. Iowa 76%
22. Michigan 75%

III. A Regional breakdown on percentage of quota attained through August 31, 1961:

Region I 67%
Region II 54%
Region III 75%
Region IV 68%
Region V 64%
Region VI 81%
Region VII 69%
Region VIII 76%

	August 1960	August 1961	Total 1960	Quota 1961	% of Quota
ALABAMA	51	47	55	77	61%
ARIZONA	30	27	30	45	60%
ARKANSAS	33	43	39	54	80%
CALIFORNIA	478	535	592	624	85%
COLORADO	86	56	90	95	58%
CONNECTICUT	88	62	88	103	60%
DELAWARE	14	15	14	17	88%
FLORIDA	86	120	87	125	96%
GEORGIA	71	73	73	100	73%
IDAHO	20	13	20	30	43%
ILLINOIS	173	167	183	250	67%
INDIANA	129	115	131	181	63%
IOWA	145	191	154	250	76%
KANSAS	50	58	52	65	89%
KENTUCKY	45	66	45	70	94%
LOUISIANA	17	33	17	27	122%
MAINE	40	54	40	60	90%
MARYLAND	68	61	69	100	61%
MASSACHUSETTS	252	241	284	400	60%
MICHIGAN	168	166	169	219	75%
MINNESOTA	109	115	109	300	37%
MISSISSIPPI	17	23	17	50	46%
MISSOURI	90	128	124	175	73%
MONTANA	20	25	21	50	50%
NEBRASKA	71	102	73	100	102%
NEVADA	2	2	2	19	10%
NEW HAMPSHIRE	58	57	59	60	95%
NEW JERSEY	77	68	84	165	41%
NEW MEXICO	15	20	15	15	133%
NEW YORK	155	113	175	210	54%
NORTH CAROLINA	65	57	68	100	57%
NORTH DAKOTA	13	15	14	15	100%
OHIO	72	60	72	122	49%
OKLAHOMA	60	126	65	100	126%
OREGON	33	19	34	44	43%
PENNSYLVANIA	109	117	110	200	59%
RHODE ISLAND	25	28	25	27	104%
SOUTH CAROLINA	21	21	21	25	84%
SOUTH DAKOTA	29	37	33	47	78%
TENNESSEE	119	117	119	131	89%
TEXAS	100	122	107	300	41%
UTAH	15	22	15	68	32%
VERMONT	41	59	41	96	61%
VIRGINIA	42	60	44	90	66%
WASHINGTON	111	116	111	133	87%
WEST VIRGINIA	30	21	30	40	53%
WISCONSIN	121	116	122	150	77%
WYOMING	22	23	22	20	115%
TOTAL MEMBERS	3,686	3,932	3,964	5,744	68%

State Associations Directory

Alabama Nursing Homes Association
President: Garland L. Rollins, P.O. Box 305, Falkville. Secretary: Mrs. J. H. Kelly, P.O. Box 88, Haleyville. Treasurer: Robert V. Santini, Route 12, Box 158, Birmingham. A.N.H.A. Governing Council Member: Garland L. Rollins.

Arizona Association of Nursing Homes
President: Mrs. Roy Williams, 1916 N. 32nd Street, Phoenix. Secretary: Ione A Dockstader, 6825 North Sixteenth Street, Phoenix. Treasurer: Mrs. Frank Maus, 9110, N. 7th Street Phoenix. A.N.H.A. Governing Council Member: Mrs. Roy Williams.

Arkansas Nursing Home Association
President: Mrs. Mason Comer, 604 W. 4th St., Lonoke. Secretary: Mrs. Jackie Kilgore, R.N., Caraway. Treasurer: Joe R. Gribble, 953 David O'Dodd Rd., Little Rock. A.N.H.A. Governing Council Member: Mrs. Ruth J. Richardson, 619 Center St., Conway.

California Association of Nursing Homes, Sanitariums, Rest Homes & Homes for the Aged, Inc.
President: Marion Gellmann, 924 Balboa St., San Francisco. Secretary: Mrs. Fern Robinson, 3201 Fernside Boulevard, Alameda. Treasurer: Birre Gipe, 541 North Fulton, Fresno. A.N.H.A. Governing Council Member: Mrs. Gellmann.

Colorado Nursing Home Association
President: H. Virgil Davis, 1427 Gaylord, Denver. Secretary: Dorothy Cording, Route 1, Eldorado Springs Road, Boulder. Treasurer: Vesta Bowden, 1455 Beeler Street, Aurora. A.N.H.A. Governing Council Member: H. Virgil Davis.

The Connecticut Chronic and Convalescent Hospital Association, Inc.
President: Theodore E. Hawkins, 1768 Whitney Ave., New Haven. Secretary: Vera Arterburn, 267 Union Ave. West Haven. Treasurer: Leander Lavigne, 157 Hillside Ave., Waterbury. A.N.H.A. Governing Council Member: Mrs. Robert Baird, North Star Route, New Milford.

Delaware Association of Nursing Homes
President: Alice Ulmer, 160 Winston Avenue, Elmhurst, Wilmington 4. Secretary: Blanche Williams, Clarksville. Treasurer: Paul J. Turek, 1506 North Broom Street, Wilmington 6. A.N.H.A. Governing Council Member: Alice Ulmer.

Florida Nursing Home Association
President: David R. Mosher, 859 10th Ave., N., St. Petersburg. Secretary: Ann Tompkins, 1006 West Main St., Leesburg. Treasurer: Frank Cuyler, 504 3rd Ave., South, Lake Worth. ANHA Governing Council Member: David R. Mosher.

The Georgia Association of Nursing Homes and Homes for the Aged
President: Thomas E. Anthony, 2725 Vineville Avenue, Macon. Secretary: William M. Crane, 663 North Milledge Street, Athens. Treasurer: Louis Newmark, 260 14th Street, N. W., Atlanta 13. A.N.H.A. Governing Council Member: Thomas E. Anthony.

Idaho Nursing Home Association, Inc.
President: Virgil Harter, Payette, Idaho. Secretary-Treasurer: Mrs. Virgil Harter, Payette, Idaho. Governing Council: Virgil Harter.

Illinois Nursing Home Association
President: Margaret Setzekorn, 1300 Broadway, Mt. Vernon. Secretary: Jeannette Kramer, 417 North Kenilworth, Oak Park. Treasurer: Helen Nelson, 205 North Main, Saybrook. A.N.H.A. Governing Council Member: Margaret Setzekorn.

Indiana Association of Licensed Nursing Homes
President: Margaret L. Nickols, 812 Riverside Avenue, Muncie. Secretary: Marjorie M. Fordyce, 321 North Morgan Street, Rushville. Treasurer: Emory H. Vollmer, 2630 North College Avenue, Indianapolis. A.N.H.A. Governing Council Member: Marjorie Pearsey, 114 East Fifth Street, Rushville.

Iowa Nursing Home Association
President: Charles B. Shindler, 1211 Pleasant Street, Des Moines. Secretary: C. B. Verdoorn, Ashton. Treasurer: W. S. Bauman, 222 North 18th Street, Clarinda. A.N.H.A. Governing Council Member: Charles B. Shindler.

Kansas Nursing Home Association, Inc.
President: L. V. Biffer, Jr., P. O. Box 812, Wichita. Secretary: Viola Wagner, 301 West First, Washington. Treasurer: Robert E. Truitt, 525 East Second Street, Tonganoxie. A.N.H.A. Governing Council Member: Louisa Joplin, Box 632, McLouth.

Kentucky Association of Nursing Homes
President: Mrs. Ann Ralph, 105 Lyndon Lane, Lyndon. Secretary: Mrs. Bernice Sisk, 419 North Seminary, Madisonville. Treasurer: Jack Bousman, 1460 South 2nd St., Louisville 8. A.N.H.A. Governing Council Member: Ira O. Wallace, New Castle Sanitarium, New Castle.

Louisiana Association of Licensed Nursing Homes, Inc.
President: Lawrence W. Lindig, 6271 Boone Ave., Baton. Secretary: Francis Kerrigan, 2445 Esplanade, New Orleans. Treasurer: Mrs. L. E. Van Mullen, 6100 Chef Menteur Highway, New Orleans. A.N.H.A. Governing Council Member: Emily Avriett, 816 Nashville Ave., New Orleans.

The Maine Association of Nursing Homes
President: Kenneth Robinson, 284 Brunswick Avenue, Gardiner. Secretary: Alzada Simmons, Western Avenue, Winthrop. Treasurer: Roy Meister, 25 Court Street, Belfast. A.N.H.A. Governing Council Member: Kenneth Robinson.

Maryland Nursing Home Association, Inc.
President: Eugene J. Lipitz, 16 Fusting Ave., Catonsville 28. Secretary-Treasurer: Lawrence J. Repetti, 98 Smithwood Ave., Catonsville 28. A.N.H.A. Governing Council Member: Eugene J. Lipitz.

Massachusetts Federation of Nursing Homes
President: Joseph H. Furlong, Jr., Frost Rd., Washington, Mass. Secretary: Sydney Nathans, M.D., 890 St. James Ave., Springfield, Mass. Treasurer: Joseph J. Alessandroni, 91 Summer St., Waltham, Mass. A.N.H.A. Governing Council Member: Frithiof B. Carlson, 44 Old Upton Rd., Grafton, Mass.

Michigan Nursing Home Association:
President: Mrs. Mabel Lilly, 241 State St., Mason. Secretary: Eldon W. Purdy, 873 S. State St., Caro. Treasurer: Mrs. Frances Sawer, 7505 Canton Center Rd., Plymouth. A.N.H.A. Governing Council Member: Mrs. Mabel Lilly.

The Minnesota Nursing Home Association
President: Sidney S. Shields, W-1252 First National Bank Building, St. Paul 1, Minnesota. Secretary: Naime Wessin, 725 Fremont Avenue, North, Minneapolis. Treasurer: Raymond C. Olson, 400 10th Avenue. N. W., Austin. A.N.H.A. Governing Council Member: Karl T. Spellum, Lester Prairie.

Mississippi Nursing Home Association
President: J. W. Pigford, Highway 39 North. Meridian. Secretary: Mary W. Majure, Route 5, Highway 11, Meridian. Treasurer: Mrs. R. S. Compere, 865 North Street, Jackson. A.N.H.A. Governing Council Member: J. W. Pigford.

Missouri Nursing Home Association
President: Walter McCarty, 3621 Warwick, Kansas City 11. Secretary: Kathryn Lindeman, 3537 Main Street, Kansas City. Treasurer: Etta Kelly, 4123 Independence Avenue, Kansas City. A.N.H.A. Governing Council Member: Walter McCarty.

Montana Nursing Home Association
President: Mary Sande, Box 156, Box Elder. Secretary: Nellie Cornelius, 208 South 35th St., Billings. Treasurer: Joe Ronchetto, 444 W. Broadway, Butte. A.N.H.A. Governing Council Member: Mary Sande, Box 156, Box Elder.

Nebraska Nursing Home Association
President: Ira Clark, 1845 D Street, Lincoln. Nebraska. Secretary: Lillian M. Clark, 1845 D Street, Lincoln, Nebraska. Treasurer: Clifford Dahl, 918 Main Street, Wayne, Nebraska. Governing Council Member: Ira Clark.

Nevada Nursing Home Association:
President: Leandro D. Tomaso, 1015 Spanish Springs Rd., Reno. Secretary-Treasurer: Beverly Tomaso, 1015 Spanish Springs Rd., Reno. A. N. H. A. Governing Council Member: Leandro D. Tomaso.

The New Hampshire Association Licensed Nursing Homes
President: Enos O. Brown, 90 Stark St., Dover. Secretary: Edwina V. Merrill, 221 Glenwood Ave., Franklin. Treasurer: Mary McKerley, 174 So. Main St., Concord. A.N.H.A. Governing Council Member: Enos O. Brown.

Licensed Nursing Homes Association of New Jersey, Inc.
President: George E. Conley, 82 North Main Street, Cranbury. Secretary: Leonard A. Coyle. 562 Lafayette Avenue, West Trenton. Treasurer: Jesse Wallace, 304 Teaneck Road, Teaneck. A.N.H.A. Governing Council Member: George E. Conley.

New Mexico Association of Nursing Homes, Inc.
President: Kathryn Vaskov, Rt. 1, Box 96-A, Las Cruces. Secretary-Treasurer: Olga Vaskov, Rt. 1, Box 96-A, Las Cruces. A.N.H.A. Governing Council Member: Kathryn Vaskov.

New York State Nursing Home Association, Inc.
President: Austin J. Barrett, 685 Linwood Ave., Buffalo. Secretary: Irene Tierney, 248 Main St., Guilderland Center. Treasurer: Alan Bartholomew, 27 South Goodman St., Rochester. ANHA Governing Council Member: Austin J. Barrett.

North Carolina Ass'n. of Nursing Homes and Homes for Aged, Inc.
Executive Board:
Chairman: Travis H. Tomlinson, 513 East Whitaker Mill Road, Raleigh. Treasurer: Mrs. Mary T. Lennon, R. 1, Box 38-A, Clarkton. President, Nursing Home Section: Mrs. Dorothy Joyner, 2623 Crescent Ave. Extension, Charlotte. President, Homes for Aged Section: Mrs. Lucy Bell, 232 East Chestnut St., Asheville. ANHA Governing Council Member: Travis H. Tomlinson.

North Dakota Association of Nursing Homes
President: Rev. R. R. Hanselman, Dickinson. Secretary: Orren Lee Northwood. Treasurer: O. H. Hove, M. D., Minot. A.N.H.A. Governing Council Member: Mrs. Don Nash, 408 6th St., Wahpeton.

Ohio Association of Nursing Homes
President: J. C. Weaver, Jr., 2157 Glenwood, Toledo. Secretary: Eileen Turner, 2111 Jefferson, Toledo. Treasurer. Bruce Levering, R.R. 3, Fredericktown. A.N.H.A. Governing Council Member: Leo Glass, 3536 Washington Ave., Cincinnati 29.

Oklahoma State Nursing Home Association, Inc.
President: Carroll E. Young, 120 East Main St., Weatherford. Secretary: Marjorie C. Magee, 2307 S. W. 27th, Oklahoma City 8. Treasurer: George Machtolff, P.O. Box 448, Guthrie. A.N.H.A. Governing Council Member: Carroll E. Young.

Oregon Nursing Homes, Inc.:
President: A. J. Roth, Dr. P.H., Lae Grande. Secretary: Shirley Franklin, 220 E. Herford St., Gladstone. Treasurer: Ruby E. Gleason, 503 N. College, Newberg. A.N.H.A. Governing Council Member: Dr. A. J. Roth.

Pennsylvania Association of Nursing and Convalescent Homes
President: Jacob I. Roe, 148 N. Charlotte Street, Lancaster. Secretary: Antoinette Swankoski, Drums. Treasurer: Catherine Fox, Warrington. A.N.H.A. Governing Council Member: Jacob I. Roe.

Federation of Licensed Nursing Homes of Rhode Island, Inc.
President: Anne Theinert, 33 Pleasant View Avenue, Greenville. Secretary: Nettie Farrell, 26 Fourth Street, East Providence. Treasurer: Anna French, 21 Bull Street, Newport. A.N.H.A. Governing Council Member: Ralph Holmes, 1224 Narragansett Boulevard, Cranston.

South Carolina Association of Nursing Homes
President: Mrs. Lillian H. Smith, R.N., 2451 Forest Dr., Columbia. Secretary-Treasurer: Rev. J. F. M. Hoffmeyer, Methodist Home for the Aging, Orangeburg. A.N.H.A. Governing Council Member: Mrs. Leora Maulden, Reynold Memorial, Edgefield.

South Dakota Association of Nursing Homes
President: Robert W. Beckwith, Chamberlain. Secretary: Elvina Mikkelson, Yankton. Treasurer: Newton Richardson, Roslyn. A.N.H.A. Governing Council Member: Robert Beckwith.

Tennessee Nursing Home Association
President George T. Mustin, 642 Semmes St., Memphis. Secretary: Catherine Anderson, 4005 Broadway, N.E., Knoxville. Treasurer: Blanche DeLaney, 1227 Sixteenth Ave., S., Nashville. A.N.H.A. Governing Council Member: George T. Mustin.

Texas Nursing Home Association
President: Sam E. McCaskill, P.O. Box 18145, Dallas, Texas. Secretary: Harry Reever, 4038 Lemmon Ave., Dallas. Treasurer: Mrs. Hugh V. Jones, 1723 Hemphill St., Fort Worth. A.N.H.A. Governing Council Member: Sam E. McCaskill.

Utah Professional Nursing Homes Association
President: Birdie Brey Hara, 119 F St., Salt Lake City 3. Secretary: Edna Buckle, 73 H St., Salt Lake City. Treasurer: Gerald Swegle, 535 2nd Ave., Salt Lake City. A.N.H.A. Governing Council Member: Samuella Hawkins, 1216 E. 13th, South, Salt Lake City.

Vermont Association of Nursing Homes
President: Milton Aylward, RFD No. 2, Waterbury. Secretary: Marion E. Zanleon, 31 Richardson St., Barre. Treasurer: Raymond Gobeil, RFD, Derby. A.N.H.A. Governing Council Member: Milton Aylward.

Virginia Association of Nursing Homes
President: Bernard Maslan, 2112 Monteiro Ave., Richmond. Secretary: Belle Wynkook, West Market St., Leesburg. Treasurer: C. Arthur Fowler, Route 1, Box 92, Blake Lane, Oakton. A.N.H.A. Governing Council Member: Martin Dalton, Box 746, Annadale.

Washington State Nursing Home Association
President: Roy J. McDonald, 907 South Mill Street, Colfax. Secretary-Treasurer: Dorothy Stilwell, 723 2nd St., N. W., Puyallup. A.N.H.A. Governing Council Member: Roy J. McDonald.

West Virginia Nursing Home Association:
President: T. J. Gilmore, P.O. Box 3193, Huntington. Secretary: Christinia Winans, Grafton. Treasurer: T. B. Gilmore, P.O. Box 3193, Huntington. A.N.H.A. Governing Council Member: T. J. Gilmore.

Wisconsin Association of Nursing Homes, Inc.
President: Dr. Elmer C. Kocovsky, P.O. Box 232, Wauwatosa 13. Secretary: Mary Bernikowicz, R. N., 6014 — 18th Ave., Kenosha. Treasurer: Pearl F. Dawson, 502 East Holmes St., Janesville. ANHA Governing Council Member: Dr. Elmer C. Kocovsky.

Wyoming Association of Nursing Homes
President: Clara Jokimaki, State Park, Thermopolis. Secretary: Wilma Bigner, West C & 14 Ave., Torrington. Treasurer: Buelah Bushmaker, 244 East Works, Sheridan. A.N.H.A. Governing Council Member: Clara Jokimaki.

Convention Schedule – American Nursing Home Assn.

Hotel Pick-Carter, Cleveland, Ohio October 2-6, 1961

SUNDAY, OCT. 1

2:00 p.m. ..... Executive Board meeting* — Rainbow Room

MONDAY, OCT. 2

8:00 a.m. to 5:00 p.m. ..... Registration
8:00 a.m. to 5:00 p.m. ..... Accreditation of Delegates
8:00 a.m. to 9:30 a.m. ..... Regional meetings — Briefing on agenda
9:45 a.m. to 12 noon ..... Governing Council meeting* — Rainbow Room
Alton E. Barlow, presiding
12 noon to 1:30 p.m. ..... Break for lunch
1:30 p.m. to 4:00 p.m. ..... Governing Council meeting*
4:00 p.m. to 6:00 p.m. ..... Formal Opening of Exhibits
Dan Fowler, presiding; A. E. Barlow, speaker
7:30 p.m. ..... Reception — Rainbow Room
"Early Birds Flock Together"
Delegates — Members — Exhibitors
Get together for fellowship

TUESDAY, OCT. 3

8:00 a.m. to 9:45 a.m. ..... Regional meetings
8:00 a.m. to 5:00 p.m. ..... Registration
8:00 a.m. to 9:30 a.m. ..... Accreditation of Delegates
10:00 a.m. to 11:30 a.m. ..... General Session — Alton E. Barlow, presiding.
Welcoming Address; Invocation
Convention Theme Speaker — Dr. Guyer,
"Ohio's Ambassador of God Will"
12:15 p.m. to 2:00 p.m. ..... Luncheon — Eldred Thomas, presiding
Invocation
Speaker — Mr. Roger Fleming,
American Farm Bureau Fed. (Fashion Show)
2:15 p.m. to 4:30 p.m. ..... Business Session — Alton E. Barlow, presiding
4:30 p.m. to 6:00 p.m. ..... Exhibits
6:00 p.m. on ..... Exhibitors' Night

WEDNESDAY, OCT. 4

7:00 a.m. to 9:00 a.m. ..... Exec. Secretaries' & State Associations' Breakfast
Chairman: Russell Adams
7:00 a.m. to 9:00 a.m. ..... State Presidents' Breakfast; Chm. Curt Weaver
8:00 a.m. to 5:00 p.m. ..... Registration
8:00 a.m. to 9:00 a.m. ..... Accreditation of Delegates
9:15 a.m. to 11:15 a.m. ..... General Session—Wm. E. Beaumont, Jr., presiding
3 Speakers & "Trading Post" Instructions
1. American Institute of Architects
2. Asso. General Contractors of America, Inc.
3. Mortgage Bankers Association of America
11:15 a.m. to 12:30 p.m. ..... Exhibits
12:30 p.m. to 2:00 p.m. ..... Luncheon — Morrill S. Ring, Sr., presiding
Invocation
Speaker — Mrs. Helen Holt, Federal Housing Adm.
Fashion Show
2:00 p.m. to 3:00 p.m. ..... Exhibits
3:00 p.m. to 5:00 p.m. ..... "Trading Post"
5:00 p.m. to 7:00 p.m. ..... Exhibits

THURSDAY, OCT. 5

9:15 a.m. to 10.15 a.m. ..... "Trading Post" Reports — Marjorie Davis, presiding
8:00 a.m. to 5:00 p.m. ..... Registration
10:15 a.m. to 11:15 a.m. ..... Business Session — Alton E. Barlow, presiding
11:15 a.m. to 2:00 p.m. ..... Exhibits
2:00 p.m. to 4:00 p.m. ..... Election of Officers
7:30 p.m. ..... Banquet; Speaker — Dr. McFarland,
Consultant for G. M. Corp.

FRIDAY, OCT. 6

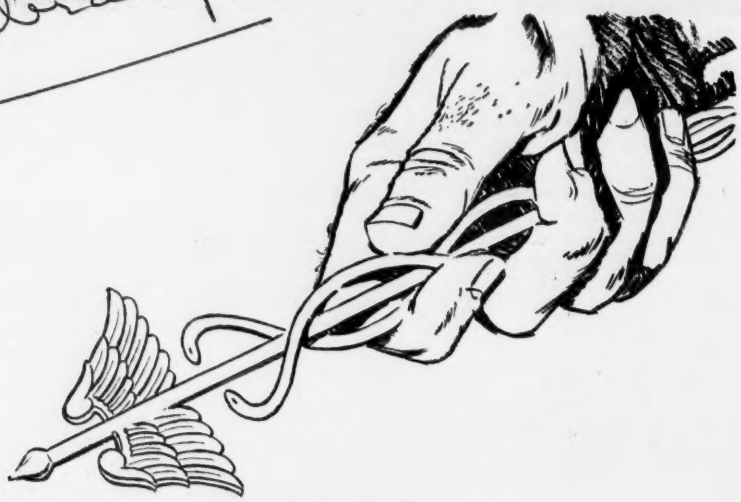
9:00 a.m. to 12 noon ..... Governing Council meeting*

*All Governing Council and Executive Board meetings are open to all members.

American Nursing Home Ass'n.
Suit 731
1346 Connecticut Ave., N.W.
Washington 6, D.C.

Dr. Felix J. Underwood
Miss. State Board of Health
Jackson, Miss.

September, 1961



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- ★ to program economic assistance
  save money for) nursing homes
  hospitals.
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  dealers sell our products with work
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**This will lower the costs of patient care
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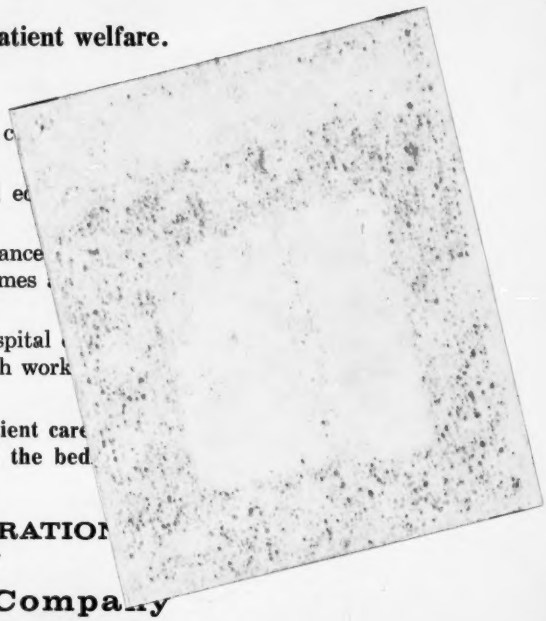

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